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ABSTRACT

The State Children's Health Insurance Program (CHIP) was designed in 1997 to support working families by providing affordable, quality health coverage for their children in an efficient, effective, and coordinated way. This report examines the progress made in implementing CHIP nationwide. Information sources included the following: (1) federal data and reports on CHIP and Medicaid by Department of Health and Human Service agencies and the General Accounting Office; (2) state CHIP plans and reports; (3) reports and technical materials by national organizations; and (4) published research in peer-reviewed journals. Among the main findings of the report are the following: (1) every state and the District of Columbia have implemented a version of CHIP, with extensive state differences in plans; (2) rankings by state on their progress in increasing coverage were based on CHIP enrollment alone and CHIP and Medicaid enrollment combined; (3) the top 10 states, based on combined CHIP and Medicaid enrollment, were Alaska, Massachusetts, Maryland, New York, Louisiana, Maine, Missouri, Nebraska, North Carolina, and Arkansas; and (4) states with higher rankings generally adopted streamlined application and enrollment procedures early, had visible leadership from key state officials, and supported aggressive, community-based outreach. The report makes recommendations to increase enrollment and coverage of uninsured children in several areas, including coverage, eligibility, ease of enrollment, improved outreach, continuous enrollment, program coordination and integration, cultural competence, immigrant children, provider participation, accountability, information technology, and family coverage. Web sites and additional resources are appended. (Contains 79 references.) (KB)

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All over the Map

A Progress Report on the State Children's Health Insurance Program (CHIP)

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Washington, DC

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CDF began in 1973 and is a private, nonprofit organization supported by foundations, corporation grants, and individual donations. We have never taken government funds.

All over the Map

A Progress Report on the State Children's Health Insurance Program (CHIP)

Margo Edmunds, PhD, Martha Teitelbaum, PhD, and Cassy Gleason

Health Division
Children's Defense Fund
Washington, DC

July 2000

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Margo Edmunds wrote the report and oversaw its development and production. Martha Teitelbaum produced and analyzed the data, and Cassy Gleason helped to analyze program information. Anourack Chinyavong designed the cover and the format. Laura Graves was the production manager. Sandra Won was the copy editor, Elizabeth Alesbury coordinated the Web version, and Lori Martin assisted with graphics.

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It is no secret to Members of this body that the United States has a deplorable record in making certain that our Nation's most vulnerable, our children, have access to health care services. By many estimates, over 10 million of our children are uninsured. That is a situation which must be corrected.... As many have noted, this will be the most important new program to help our Nation's children since enactment of the Medicaid Program over 30 years ago.... In adopting this legislation today, we are representing our constituents, the large majority of which time and time again have signaled they want to do more for children's health. That day is here.

Senator Orrin Hatch, *Congressional Record*, July 31, 1997

Today we celebrate an unprecedented achievement for America's working families and their children. When Senator Hatch and I introduced our children's health insurance proposal last March, our goal was to guarantee good health care for millions of children who have been left out and left behind. Now, with the enactment of the budget legislation, Congress is taking a giant step toward fulfilling that commitment....This landmark measure represents the most far-reaching step that Congress has ever taken to help the nation's children....This is truly a bipartisan victory for the millions of uninsured children across America.

Senator Edward M. Kennedy, *Statement on Children's Health*, July 31, 1997

Executive Summary

Creation of the State Children's Health Insurance Program (CHIP) in 1997 marked a historic commitment to expanding health care coverage for children. Building on Medicaid, enacted more than 30 years earlier, CHIP was intended to bridge the insurance gap for low-income working families who earn too much to qualify for Medicaid but can not afford to buy insurance on their own or through an employer.

"Two-thirds of the nation's uninsured children are eligible for coverage through CHIP or Medicaid. More than 2 million uninsured children are still eligible for CHIP, and 4 to 5 million children are eligible for Medicaid."

At the time CHIP was being debated, an estimated 11.3 million children were uninsured. Since that time, the total number of uninsured children has increased to almost 12 million. A significant reason more children are uninsured today is that hundreds of thousands of children were wrongfully dropped from Medicaid coverage after enactment of the welfare law in 1996.

Clearly, the impact of CHIP can not be assessed without looking at the Medicaid program. Two-thirds of the nation's uninsured children are eligible for CHIP or Medicaid. More than 2 million uninsured children are still eligible for CHIP, and 4 to 5 million children are eligible for Medicaid.

Trends in the private insurance market also have an impact on CHIP. Some states have stronger economies and a higher proportion of employers providing coverage for employees and their families. In some states, such as California, even the current strong economy has not created more jobs with health insurance benefits. An economic slowdown or an increase in the cost of private insurance premiums could reduce the number of working Americans with private coverage and lead to an increase in the number of uninsured children who would be eligible for CHIP.

Why Is Health Insurance So Important?

There is no question that insurance is key to maintaining good health. Children without insurance are more likely to have health problems that could be prevented or managed with routine health care.

Executive Summary

"The differences among state plans are so extensive that now we essentially have 51 different CHIP programs in various stages of reaching and enrolling eligible children."

Uninsured children in low-income families get sick more often from preventable acute and infectious illnesses such as conjunctivitis and ear infections. Low-income children are also more likely to suffer from lead poisoning, serious dental problems, and chronic medical conditions such as asthma and diabetes.

One out of three Hispanic children and one out of five Black children are uninsured, compared with one out of nine White children. Studies show that health status is largely affected by race, language, culture, geography, and economics. In other words, communities of color have more uninsured children and more children in poorer health. To respond to this pressing problem, the U.S. Surgeon General has committed the nation's public health system to reducing racial differences in health status by 2010.

Insurance coverage is the necessary first step toward improving children's access to health care. Passage of CHIP reflects a strong national commitment to make affordable coverage available for children in working families. But the promise of CHIP remains unfulfilled as long as eligible children have not been enrolled in the program.

CHIP provides states with federal matching grants to insure children by expanding Medicaid, supporting a separate state program, or using a combination of these approaches. States have flexibility in setting eligibility and cost-sharing requirements, designing enrollment strategies and benefits packages, and measuring program performance.

Progress in Implementing CHIP

Participation in CHIP is voluntary, but every state and the District of Columbia have implemented a version of the program. Each of the territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands) is also participating, but they are not covered in this report.

CHIP enrollment reached 2 million by the end of September 1999, according to the Department of Health and Human Services' Health Care Financing Administration (HCFA). More than 1.2 million children were enrolled in separate programs, and almost 700,000 were enrolled in Medicaid expansions.

The differences among state plans are so extensive that now we essentially have 51 different CHIP programs in various stages of reaching and enrolling eligible children. As this report shows, progress in implementing CHIP is clearly "all over the map."

How Do States Rank in Increasing Coverage?

To compare states' progress in increasing children's health insurance coverage, the Children's Defense Fund (CDF) ranked state progress in two ways: CHIP enrollment alone and CHIP and Medicaid enrollment combined. First, we set a target number of uninsured children for each state and calculated the states' average monthly rates of progress toward covering the target number. We then ranked the states from highest to lowest according to their average monthly progress rates.

To set the target number for each state, we used the Census Bureau's estimated number of uninsured children in the state at or below 200% of the Federal Poverty Level (FPL) ($34,100 for a family of four) because that was a factor in calculating state funding allotments for CHIP. For enrollment numbers, we used the most recent official data from HCFA on CHIP (FY 1999) and Medicaid (FY 1997 and FY 1998).

These calculations provide a consistent way to compare state progress in increasing health insurance coverage because the rankings show enrollment as a proportion of the target number of uninsured children and thus reflect the intensity of enrollment efforts. States implemented their CHIP programs at different times, so the average monthly progress rate is a consistent way to measure performance while adjusting for the different lengths of time the programs have been operating in different states.

More recent enrollment numbers might reflect a different picture for states that have increased eligibility levels, improved outreach, and simplified enrollment procedures since the years covered in the report. Also, some relatively large differences in rankings may be based on relatively small differences in progress rates. However, nine states actually lost ground in covering uninsured children during 1998 and 1999, primarily because of large drops in their Medicaid enrollment. Again, if more recent information were available, state rankings might change.

Hawaii, Washington, and Wyoming are not ranked because they did not implement CHIP programs until after September 30, 1999. Minnesota is not ranked because it already had an expanded Medicaid program for children at a very high eligibility level before CHIP. As a result, only a very small number of children in Minnesota are CHIP-eligible.

TABLE 1

How Do States Rank in Increasing Coverage?

RANKINGS: BEST TO WORST*

Rank	CHIP and Medicaid Combined	Rank	CHIP Alone
1	Alaska	1	Alaska
2	Massachusetts	2	New York
3	Maryland	3	Massachusetts
4	New York	4	Missouri
5	Louisiana	5	Maine
6	Maine	6	North Carolina
7	Missouri	7	New Jersey
8	Nebraska	8	Wisconsin
9	North Carolina	9	Oregon
10	Arkansas	10	Kansas
11	New Jersey	11	Pennsylvania
12	South Carolina	12	Vermont
13	Pennsylvania	13	Delaware
14	Delaware	14	Georgia
15	Utah	14	Utah
16	Georgia	16	Colorado
17	Connecticut	17	Ohio
18	Rhode Island	18	Florida
19	Vermont	19	Nebraska
20	Colorado	20	South Carolina
21	Ohio	21	Rhode Island
22	Indiana	22	District of Columbia
23	Nevada	23	Nevada
24	Alabama	24	New Hampshire
25	Idaho	25	Kentucky
26	Kansas	26	Virginia
27	New Mexico	27	Arizona
28	Iowa	28	Alabama
29	Florida	29	Connecticut
30	Oklahoma	29	South Dakota
31	South Dakota	31	Maryland
32	Kentucky	32	West Virginia
33	New Hampshire	33	Idaho
34	Arizona	34	Oklahoma
35	Mississippi	35	Louisiana
36	California	36	Michigan
37	Illinois	37	Indiana
38	Virginia	38	Iowa
39	Texas	39	Illinois
40	District of Columbia	40	California
41	West Virginia	41	Mississippi
42	North Dakota	42	New Mexico
43	Montana	43	Montana
44	Tennessee	44	Tennessee
45	Wisconsin	45	Texas
46	Michigan	46	North Dakota
47	Oregon	47	Arkansas

Rankings are based on the average monthly rates of progress in enrolling eligible children. Each state's target was the number of uninsured children at or below 200% of Federal Poverty Level in the state.

* Hawaii, Washington, and Wyoming are not ranked because they had not implemented CHIP programs by the end of FY 1999. Minnesota is not ranked because so few children are eligible for CHIP due to a pre-existing children's Medicaid expansion with very high eligibility levels.

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WHY THE NUMBERS DON'T ALWAYS MATCH

Some states, such as California and Maine, use their own survey information for planning and resource allocation. But not every state has done its own surveys, and many surveys use different methods or cover different time periods, making it difficult to compare numbers from state to state. For example, in *One Step Forward, One Step Back*, Families USA collected 1996-1999 enrollment information from 12 states with the largest numbers of uninsured children, and in a report on CHIP and Medicaid prepared for the Kaiser Commission on Medicaid and the Uninsured, the Center on Budget and Policy Priorities conducted a survey of all 50 states. For this report, CDF chose to use the Bureau of the Census estimates on the number of uninsured children at or below 200% of the Federal Poverty Level in each state because these numbers were one of the factors used in calculating state funding allotments for CHIP and they represent the target population of uninsured children at the beginning of CHIP. CDF also chose to use the most current official enrollment data from the Health Care Financing Administration on CHIP (FY 1999) and Medicaid (FY 1997 and 1998). Because numbers used in our study are based on federal sources, they may vary from the numbers used in other studies.

Key Findings

Top 10 List: CHIP and Medicaid Combined

- Alaska, Massachusetts, Maryland, New York, Louisiana, Maine, Missouri, Nebraska, North Carolina, and Arkansas were ranked as the top 10 states based on combined CHIP and Medicaid enrollment. Together, these 10 states have enrolled almost 1.1 million children in CHIP and Medicaid expansions. Six of the top 10 states implemented CHIP through Medicaid expansion plans, three have combination plans, and one has a separate state program. Three out of the 10 states (Alaska, Massachusetts, and New York) have spent all of their FY 1998 funding allotment.
- Of the 10 states with the largest pre-CHIP *percentages* of uninsured children at or below 200% of FPL ($34,100 for a family of four), Louisiana and Arkansas ranked in the top 10 in the combined rankings, largely because of increases in Medicaid enrollment.

Top 10 List: CHIP Alone

- Alaska, New York, Massachusetts, Missouri, Maine, North Carolina, New Jersey, Wisconsin, Oregon, and Kansas were at the top of the list in CHIP enrollment. Four are combination plans, three are Medicaid expansions, and three are separate state programs. Together, these 10 states enrolled 848,000 children.

Meeting the Goal

- Although more than half of the states have set CHIP eligibility at 200% of FPL or higher, states with higher state rankings generally adopted streamlined application and enrollment processes early on, had visible leadership from key state officials, and supported aggressive and community-based outreach.

"Regular" Medicaid Enrollment

- Medicaid enrollment increased by nearly 58% in Maryland; Louisiana, Massachusetts, and Arkansas had enrollment increases of 41%, 32%, and 26%, respectively. Eighteen states stayed about the same or had increases of up to 11%. The other 27 states had decreases in enrollment. (Data were not available for Hawaii and Oklahoma.)

Big States with Big Gaps

- The two states with the largest *numbers* of uninsured children at or below 200% of FPL — California (1.3 million) and Texas (1 million) — ranked near the bottom on both sets or rankings. For CHIP enrollment alone, California ranked 40th and Texas was 45th. For the combined enrollment, California ranked 36th and Texas was 39th.

Net Losses in Coverage

- Nine states — District of Columbia, Michigan, Montana, North Dakota, Oregon, Tennessee, Texas, West Virginia, and Wisconsin — showed net increases in the number of uninsured children because their Medicaid enrollment decreased substantially.
- Together, California, Michigan, and Texas accounted for more than 300,000 of the children who lost Medicaid between FY 1997 and FY 1998.

Recommendations

CDF developed the following recommendations based on our analysis of official federal data; published studies; information from federal, state, and private sources; and interviews with key analysts, researchers, and policy makers.

In order to increase enrollment and coverage of uninsured children, states must take several steps.

Coverage

Expand coverage for CHIP and Medicaid as high as possible.

Eligibility

Raise income eligibility requirements to make them consistent for all ages of children through age 18 within a family.

Simplification and Ease of Enrollment

Streamline the CHIP and Medicaid application processes, make them user-friendly, and eliminate differences between them.

Improved and Expanded Outreach

Intensify efforts to help children get enrolled in CHIP and Medicaid.

Continuous Enrollment

Help children stay enrolled in CHIP and Medicaid through 12-month continuous eligibility. (Once determined to be eligible, children receive 12 months of coverage regardless of changes in family circumstances.)

Program Coordination and Integration

Improve coordination between CHIP and Medicaid and coordinate both with other programs for low-income families.

Cultural Competence

Recognize diversity and improve cultural sensitivity in all systems that serve children and families.

Immigrant Children

Intensify efforts to reach and enroll children in immigrant families.

Provider Participation

Recruit more providers for CHIP and Medicaid to improve access to care for low-income people and make payment rates comparable to the commercial market.

Accountability

Hold CHIP and Medicaid agencies accountable for providing all covered services, including medical, dental, vision, hearing, and behavioral (mental) health, case management, and support services, and for providing information on utilization of those services.

Better Information

Improve the use of information technology to streamline enrollment and provide the public with information on program performance at the national, state, and local levels.

Family Coverage

Secure funding to provide insurance coverage for parents of children in CHIP and Medicaid.

"Low-income children are more likely to suffer from lead poisoning, serious dental problems, and chronic medical conditions such as asthma and diabetes."

Summary

CHIP was designed to support working families by providing affordable, quality health coverage for their children in an efficient, effective, and coordinated way. States have made substantial progress in implementing CHIP but much more remains to be done. To ensure that CHIP is fully implemented and every child receives affordable coverage, states must take action immediately to ensure that Medicaid and CHIP enrollment efforts are reaching every eligible child in every community.

States should improve their information systems and community-based outreach efforts to help them identify every eligible child, simplify and improve their systems to make them easier for families to navigate, support a full range of child-appropriate health care and enabling services, and hold health plans and providers accountable for providing timely information on use and outcomes of services. For CHIP to fulfill its promise, every child eligible for CHIP or Medicaid must be enrolled and the program must be fully implemented.

States' performance under CHIP has been, quite literally, all over the map on any dimension that can be measured — eligibility levels, types of programs, implementation timetables, scope of benefits, relationship between CHIP and Medicaid, approaches to outreach, and progress in identifying and enrolling eligible children. Some states already have taken major steps to improve coverage, and they have succeeded through a variety of strategies: building on existing programs, coordinating CHIP and Medicaid, and simplifying and streamlining enrollment procedures early on.

In addition to strong coordination and collaboration between CHIP and Medicaid programs, strategic and aggressive outreach efforts also have increased enrollment. States that recognize and respect diversity in communities have succeeded through culturally appropriate outreach efforts involving community-based organizations.

Finally, leadership plays a key role in state successes. States with strong public leaders — governors, legislators, and other state officials — set high eligibility levels, promoted CHIP through highly visible endorsements, and ensured that state agencies became more family-friendly, using strategies such as short applications and simple enrollment processes for both programs.

In sum, there are many ways for states to successfully provide coverage for children. Every state should be doing everything it can to make sure that the opportunity for coverage becomes a reality for every eligible child.

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The Promise of CHIP

Title XXI of the Social Security Act, the State Children's Health Insurance Program (CHIP), became law in August 1997. The intent of the legislation was to provide "child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children" (P.L. 105-33). CHIP's passage marked a historic national commitment to expanding health care coverage for children.

> **CHIP's passage marked a historic national commitment to expanding health care coverage for children.**

CHIP was designed to give states flexibility in trying a variety of approaches to expanding coverage for working families. Nationally, two out of three children are insured through a parent's employer, and nine out of 10 uninsured children live with a parent who works. Building on Medicaid, enacted more than 30 years earlier, CHIP was intended to bridge the insurance gap for low-income working families who earn too much to qualify for Medicaid but can not afford to buy insurance on their own or through their employers.

In 1998, there were 76 million children aged 0 to 18 (CPS).

51.4 million had private insurance (CPS).

11.9 million were uninsured (CPS).

In addition, 22.3 million children aged 0 to 20 had Medicaid (HCFA).

Within a given year, children can have more than one source of coverage.

Sources: Current Population Survey (CPS) and HCFA 2082 data.

Children Need Health Insurance

Without health insurance, children are far less likely to get medical care when they are sick or injured. Compared with insured children, uninsured children are:

- Up to ten times less likely to have a regular health care provider (American College Physicians-American Society of Internal Medicine, 1999; Simpson et al., 1997);
- Four times more likely to delay seeking care when it is needed (Newacheck et al., 1998);
- Five times more likely to use the emergency room as a regular place of care (Simpson et al., 1997); and
- Six times less likely to fill a prescription because of cost (Berk, Schur, and Cantor, 1995).

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TABLE 2

Do Businesses Care About the Uninsured?

	Small Businesses (10-99 employees)	Mid-Size Businesses (100-999 employees)	Large Businesses (1,000+ employees)
Percentage that are "very" or "somewhat" concerned about uninsured children:	94%	89%	86%
Percentage that "strongly" or "somewhat" agree that every child should be guaranteed some basic level of care:	92%	96%	95%

Source: Meyer J, Naughton DH, Perry MJ. *Assessing Business Attitudes on Health Care.* Washington DC: Economic and Social Research Institute and Matthew Greenwald and Associates, 1996.

One sixth grader — on his first dental visit ever — had six teeth pulled and was forced to miss a few days of school. Afterward, he said to his principal, "I never knew what it felt like not to be in pain."

State of the State speech
by Vermont Governor Howard Dean, January 4, 2000

The general public supports children's health insurance: most polls and surveys find that 85% to 90% of their participants believe children should be insured (Blendon et al., 1999; Lake Snell Perry and Associates, 1999; W.K. Kellogg Foundation, 1999). The business community also supports insurance coverage for children: nine out of 10 employers in a national survey said they were concerned about uninsured children and believed that every child should have some basic level of health care (see Table 2).

Nine out of 10 Americans favor "making sure all families and children have access to affordable health insurance coverage," and seven out of 10 would be willing to pay as much as $50 in taxes per year to assure that all Americans were insured.

Health Coverage America, a national survey
by Lake Snell Perry and Associates, October 12, 1999

Insured children are more likely to have seen a physician in the past year, regardless of whether the source of coverage is Medicaid or private insurance (about 85% of insured children compared with about 65% of uninsured children) (Newacheck et al., 2000a). Clearly, every child needs to have insurance coverage.

Much Has Been Done

The most recent HCFA figures show that 2 million children have become newly insured through the CHIP program, and the number could reach 3 million by the end of the year 2000 (HCFA, 2000). But CHIP is having a larger impact than its enrollment figures would indicate. CHIP outreach efforts have found more than one new Medicaid enrollee for every CHIP-eligible child, including hundreds of thousands of children who wrongfully lost their Medicaid coverage, due in part to state administrative errors and oversights in implementing welfare-to-work policies (U.S. GAO, 1999, 2000).

> *This is a great day for the children of Arizona. This program will help ensure that children receive preventive health services and that sick children get the medical care they need to enable them to do what children do best — learn and play.*
>
> Arizona Governor Jane Hull, *The Arizona Republic*, September 19, 1998

"In communities of color, more children are uninsured and more children are in poorer health. One out of three Hispanic children and one out of five Black children are uninsured, compared with one out of nine White children."

TABLE 3

Who Are the Uninsured Children?

Race and Ethnicity

5.2 million	are White.
3.6 million	are Hispanic.
2.4 million	are Black.
540,000	are Asian or Pacific Islander.
151,000	are American Indian or Alaskan Natives.

Family Structure

9.4 million	have at least one working parent.
6.9 million	have at least one parent who works full-time throughout the year.
7.9 million	live in families with incomes above the Federal Poverty Level.
6.4 million	live in a two-parent household.

Notes:

Children are younger than 19.

Children of Hispanic origin are excluded from the other racial and ethnic categories. Insurance, income, and employment information are for 1998; all other information is for March 1999.

Source: U.S. Department of Commerce, Bureau of the Census, March 1999 Current Population Survey. Calculations by the Children's Defense Fund.

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The Promise of CHIP

CHIP is having a larger impact than its enrollment figures would indicate.

Nationally, CHIP is being used as a platform to bring together new and different constituencies and programs to improve the well-being of children. In most states, CHIP has significant leverage because it is an innovative source of funding. Governors, state legislators, and other public officials have promoted the program in speeches, helped with publicity, and encouraged the program's development.

Working families should not have to choose between paying for groceries or health insurance. It is imperative that every family in the Commonwealth know that their children have access to health insurance.

Massachusetts Governor Paul Cellucci, *Telegram and Gazette*, August 25, 1998

Nationally, CHIP is being used as a platform to bring together new and different constituencies and programs to improve the well-being of children.

State health departments and Medicaid agencies have changed their applications and streamlined enrollment processes, created toll-free hotlines and Web sites, and launched public awareness and marketing campaigns. Behind every child who has been enrolled in CHIP and Medicaid, there are several individuals in the public and private sectors working to make the enrollment successful. Countless public officials, advocates, community leaders, providers, students, teachers, volunteers, and celebrities across the country have been contributing their time and resources to help the program succeed.

My son had a high fever so I took him to the emergency room. But there, unless your child is dying, they do not take care of you quickly. My son was screaming. My nerves were frayed. I was so frustrated seeing him suffer. I wondered if this treatment was because I didn't have insurance. You think that the person they see before you got in quicker because they do have health insurance.

Mother in New York City, Participant in focus group conducted for CDF by Fallon McElligott, 1998

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PeachCare for Kids, Georgia's plan to reach 300,000 eligible children, used an integrated marketing program designed by the Georgia Department of Community Health with Prospect Associates. Early in 2000, the program received an award as Public Service Campaign of the Year from PRWeek, the public relations industry's leading weekly magazine. PeachCare used an integrated marketing program with statewide radio and television advertising, grassroots organizing, press events, newspaper stories, a statewide sign-up day (co-sponsored by more than 100 hospitals), and a back-to-school sign-up event at Kmart. Almost 100,000 applications have been received; 50,000 have been enrolled; and including referrals to Medicaid, more than 60,000 children have coverage for the first time.

PRWeek Awards 2000, Public Service Campaign of the Year

By the spring of 2000, CHIP reached the halfway point of its first five years of funding and appeared to be about halfway toward its enrollment goal.

Where Are We Now?

By the spring of 2000, CHIP reached the halfway point of its first five years of funding and appeared to be about halfway toward its enrollment goal. Most states have not drawn down their full funding allotments for the first year of the program. However, when CHIP was passed, states were given three years to use each fiscal year's allocation because Congress recognized they would need time to get programs up and running.

At least 2 million eligible children still need to be enrolled in CHIP, and up to 5 million children who are eligible for Medicaid are not yet enrolled (Selden et al., 1998; Short et al., 1996). This is an ideal time to assess CHIP's progress, to identify barriers to further progress, and to recommend areas for future activity and advocacy.

CHIP was designed to support working families by providing affordable, quality health coverage for their children in an efficient, effective, and coordinated way. For CHIP to fulfill its promise, much more must be done to ensure that every eligible child is enrolled, the program is fully implemented, and millions of children can get the health care they deserve.

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Who Has Helped With CHIP Outreach?

In February 1998, President Clinton asked eight federal departments with programs that serve children to develop interagency efforts to increase public awareness and to identify and enroll children in CHIP. The Department of Health and Human Services (HHS) led an Interagency Children's Health Outreach taskforce, which proposed more than 150 single-event and ongoing activities, including these:

- An outreach training kit was developed and more than 200,000 outreach posters were distributed to federal grantees, field offices, and human services agencies associated with the Departments of Health and Human Services, Housing and Urban Development, Agriculture, Education, Treasury, Labor, Interior, and the Social Security Administration.
- Thousands of AmeriCorps volunteers are serving in clinics as outreach workers, providing information and assistance with applications.
- The Internal Revenue Service provided information on CHIP and Medicaid to more than 8,000 Voluntary Income Tax Assistance volunteers.
- The Department of Agriculture coordinated CHIP outreach efforts with the free and reduced school lunch program by creating a prototype application for parents to request information on children's insurance.
- The Department of Education encouraged state and local school districts to promote CHIP.

National organizations also have been active, launching initiatives such as these:

- The National Education Association has been using newsletters, conferences, and special training sessions to educate teachers about health insurance opportunities for children.
- The American Hospital Association has launched a Campaign for Coverage to engage hospitals in helping reduce the number of uninsured children and adults through outstationing eligibility workers in hospitals, hiring former state Medicaid staff to work in admitting offices, training medical and administrative staff to identify children who may be eligible for CHIP or Medicaid, and other activities.
- The American Academy of Pediatrics is collaborating with America's Promise to mobilize corporations and communities in outreach efforts.
- Technical assistance, outreach and enrollment kits, and training have been provided to state and local governments and community-based organizations by national organizations such as the Center on Budget and Policy Priorities, Children's Defense Fund, Consumers Union, Families USA, National Association of Child Advocates, and others.

Public-private initiatives include the following:

- With a grant from Bell Atlantic, the National Governors' Association and HHS launched a toll-free number (877-KIDS-NOW) that directs callers to the CHIP enrollment agency in their home state. A Web site was added in fall 1999 (www.insurekidsnow.gov).
- A national radio advertising campaign was launched to promote public awareness about 877-KIDS-NOW, including a four-week paid radio campaign in major media markets and Public Service Announcements in English and Spanish distributed to 4,000 radio stations across the country.

Foundation initiatives include the following:

- Private foundations have committed millions of dollars to help implement CHIP at national, state, and local levels. More than 40 foundations have funded programs to find and enroll eligible children in CHIP, according to Grantmakers in Health.
- The Robert Wood Johnson Foundation has provided $48 million for the Covering Kids Initiative, which will fund innovative state-local coalitions to design and conduct outreach, help to streamline enrollment processes, and coordinate existing coverage programs in every state.
- The Kaiser Family Foundation will spend up to $10 million over five years on studies of children who are eligible but do not enroll in existing programs.
- The Blue Cross Blue Shield of Michigan Foundation and several other foundations are providing grants for community groups to do outreach and provide assistance with applications, including bilingual and bicultural staff to reach racial and ethnic minorities.

Corporate efforts include the following:

- Proctor and Gamble provided information on CHIP in its childbirth education packages that accompany Pampers diapers.
- Safeway, CVS, and other national chain grocery and drug stores provide information about the toll-free number to their customers and often allow outreach workers to provide information onsite.
- In a tri-state regional effort, Kmart, Martha Stewart Living Omnimedia, and the Children's Defense Fund launched a print, radio, and television campaign in New York, New Jersey, and Connecticut to increase public awareness about CHIP.

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States and communities have distributed CHIP applications in many locations, including these:

Health care delivery sites, including hospitals; state, city, and county health departments; federally qualified health centers; county health clinics; community health centers; clinics run by the Women, Infants and Children's Nutrition (WIC) program; offices of physicians and dentists; managed care organizations; mobile health vans; pharmacies

Government offices, including Medicaid offices; welfare offices; regional offices of the state government; unemployment offices

Schools and child care centers, including Head Start programs; elementary, junior, and high schools; local school district offices; State Department of Education offices; athletic facilities

Community-based and not-for-profit sites, including faith-based organizations; libraries; private social service agencies; legal services; advocacy groups; Boys and Girls clubs; domestic violence shelters; food banks

Some governors have actively promoted their CHIP programs. For example, Governor Frank O'Bannon of Indiana has made personal appearances with "Dr. Whoosier," the Hoosier Healthwise mascot, at public events, and the state has a toll-free number, mail-in application, and 500 enrollment centers in convenient locations.

Sources: 1) American Public Human Services Association. *CHIP Outreach and Enrollment: A View from the States.* Available at http://medicaid/aphsa/org/pubs/chip99.pdf. 2) Department of Health and Human Services. *The State Children's Health Insurance Program: HHS Fact Sheet, February 24, 2000.* Available at www.hhs.gov/news/press/2000pres/20000224a.html.

Findings

CHIP's progress has been, quite literally, all over the map on any dimension that can be measured — eligibility levels, types of programs, implementation timetables, scope of benefits, relationship between CHIP and Medicaid, approaches to outreach, and progress in identifying and enrolling eligible children.

"CHIP's progress has been, quite literally, all over the map on any dimension that can be measured — eligibility levels, types of programs, implementation timetables, scope of benefits, relationship between CHIP and Medicaid, approaches to outreach, and progress in identifying and enrolling eligible children."

To assess CHIP's progress, CDF reviewed the following information:

- Official federal data, written guidance, and reports on CHIP and Medicaid enrollment, insurance coverage, and health status by several Department of Health and Human Services (HHS) agencies and the U.S. General Accounting Office (GAO);
- State CHIP plans and reports by state-focused policy groups, such as the National Academy for State Health Policy, California's 100% Campaign, the Medi-Cal Policy Institute, the United Hospital Fund in New York, and the University of Southern Maine's Institute for Health Policy and Institute for Child and Family Policy;
- Reports and technical materials published by national organizations, including the Alliance for Health Reform, Alpha Center, American Academy of Pediatrics, Center on Budget and Policy Priorities, Center for Health Care Strategies, Children's Dental Health Project, Employee Benefits Research Institute, Economic and Social Research Institute, Families USA, Institute for Health Policy Solutions, Kaiser Commission on Medicaid and the Uninsured, National Academy of Sciences, National Association of Child Advocates, National Association of Insurance Commissioners, National Center for Studying Health Systems Change, National Conference of State Legislatures, the National Governors' Association, National Health Policy Forum, and the Urban Institute; and
- Published research in peer-reviewed journals, including *Health Affairs, Inquiry, Journal of the American Medical Association*, and *Pediatrics*.

We also interviewed national and state experts on child health funding, outreach, advocacy, health services research, and the private insurance market.

"CHIP's design gives states flexibility to try a variety of approaches to expand coverage for children in working families, using public- and private-sector approaches."

Variety: Progress and Pitfalls

States vary widely in the extent of insurance coverage for children. State percentages of uninsured children (at all levels of income) range from 6.4% (Vermont) to 25.9% (Arizona) (see Figure 1).

CHIP's design gives states flexibility to try a variety of approaches to expand coverage for children in working families, using public- and private-sector approaches. Although participation in CHIP is voluntary, every state and the District of Columbia have implemented a variation of the program. The territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands) also are participating, but they are not covered in this report.

FIGURE 1

All Uninsured Children by State

Source: Bureau of the Census: *March Current Population Survey 1997-1999*. Estimates are based on three years of CPS data because of small sample sizes in some states. Sorted by rounded percentages of uninsured. Includes children at all income levels.

Calculations by the Children's Defense Fund, November 1999.

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Findings

As of January 2000, 19 states had implemented CHIP by expanding Medicaid (increasing income levels or age of eligibility), 15 states had separate state programs (either existing or new programs), and 17 states had combination programs, which expanded Medicaid and supported a separate program (HCFA, 2000a). Each state's federal allotment is based in part on the number of uninsured children who live in families with incomes below 200% of the Federal Poverty Level (FPL), currently $34,100 for a family of four.

The programs undergo continuous revisions: 39 states have proposed amendments to their original plans, and many states that originally implemented modest Medicaid expansions have launched separate programs (NGA-NCSL, 1999).

Thus, each state could eventually support three programs: "regular" Medicaid, a Medicaid expansion under CHIP, and a new or existing separate program. States could also do regional pilot programs under CHIP, which (unlike Medicaid) does not require statewide implementation. Anticipating this variety, Congress also emphasized coordination among CHIP, Medicaid, and "other sources of health benefits coverage for children" (P.L. 105-33).

CHIP is not only providing new insurance coverage for more than 2 million children, it is promoting systems change in the public sector from the top down and from the ground up. From the beginning of the program, HCFA has urged states to make it easy for eligible children to enroll through presumptive eligibility, short applications, coordination of CHIP and Medicaid applications, elimination of asset tests, and other family-friendly procedures (HCFA, 1998, 1999).

"CHIP is not only providing new insurance coverage for more than 2 million children, it is promoting systems change in the public sector from the top down and from the ground up."

When my son gets sick, the first thing that comes to my mind is where am I going to take him and how am I going to pay?

Parent in Jackson, Mississippi, Participant in focus group conducted for CDF by Fallon McElligott, 1998

TABLE 4

Who Is Eligible for CHIP? (As of January 1, 2000)

State	Upper Income Eligibility as Percent of Federal Poverty Level (FPL)	Program Type
New Jersey	350	Combination
Connecticut	300	Combination
Missouri	300	Medicaid
New Hampshire	300	Combination
Rhode Island	300*	Medicaid
Vermont	300	Separate
Minnesota	280*	Medicaid
California	250	Combination
Washington	250	Separate
New Mexico	235	Medicaid
Alabama	200	Combination
Alaska	200	Medicaid
Arizona	200	Separate
Delaware	200	Separate
District of Columbia	200	Medicaid
Florida	200	Combination
Georgia	200	Separate
Indiana	200	Combination
Kansas	200	Separate
Kentucky	200	Combination
Maryland	200	Medicaid
Massachusetts	200	Combination
Michigan	200	Combination
Mississippi	200	Combination
Nevada	200	Separate
North Carolina	200	Separate
Pennsylvania	200	Separate
Texas	200	Combination
Utah	200	Separate
New York	192*	Combination
Colorado	185	Separate
Hawaii	185	Medicaid
Illinois	185*	Medicaid
Iowa	185	Combination
Maine	185*	Combination
Nebraska	185	Medicaid
Oklahoma	185	Medicaid
Virginia	185	Separate
Wisconsin	185	Medicaid
Oregon	170	Separate
Idaho	150	Medicaid
Louisiana	150	Medicaid
Montana	150	Separate
Ohio	150*	Medicaid
South Carolina	150*	Medicaid
West Virginia	150	Combination
North Dakota	140	Combination
South Dakota	140	Medicaid
Wyoming	133	Separate
Arkansas	100*	Medicaid
Tennessee	100*	Medicaid

NOTES

This table reports eligibility levels approved by HCFA as of January 1, 2000. Since that date, some states may have submitted amendments to change their eligibility levels, but by June 2000, only Illinois had received final approval. In some states, eligibility levels may be higher than the official levels listed here by allowing some of applicants' income to be "disregarded" (see New York as an example). In such states, work-related expenses such as child care and transportation may be subtracted from a family's gross earnings to arrive at a "net income," which is used to determine program eligibility.

***Arkansas:** The state has a Medicaid waiver for a demonstration project with eligibility up to 200% of FPL. For CHIP, 17- and 18-year-olds up to 100% of FPL are eligible.

***Illinois:** On March 30, 2000, HCFA approved the state's proposal to cover children up to 185% of FPL in its separate state program.

***Maine:** The state implemented an eligibility level of 200% of FPL on October 1, 1999 and is waiting for HCFA approval.

***Minnesota:** Before CHIP, the state expanded Medicaid eligibility to levels far higher than CHIP eligibility in other states. The only children specifically eligible for CHIP in Minnesota are those younger than 2 with family incomes from 275% to 280% of FPL.

***New York:** Although 192% of FPL is the upper eligibility for CHIP in New York, a certain amount of income may be disregarded, thus raising the overall level to an estimated 230% of FPL.

***Ohio:** CHIP eligibility has been raised to 200% of FPL, effective July 2000.

***Rhode Island:** HCFA has approved eligibility for up to 300% of FPL, but the program has only been implemented up to 250% of FPL.

***South Carolina:** Children under age 1 are covered up to 185% of FPL within regular Medicaid.

***Tennessee:** The state's Medicaid waiver has no upper eligibility level. CHIP eligibility is limited to 15- to 18-year-olds up to 100% of FPL.

Source: HCFA, *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998-September 30, 1999.* See www.hcfa.gov.

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As of January 2000, the following had been accomplished:

Eligibility

- All 50 states and the District of Columbia have had their original CHIP plans approved (HCFA, 2000a). Programs will continue to change as state amendments to original plans receive approval from HCFA.
- Income eligibility for 19 CHIP programs is set at 200% of the Federal Poverty Level (FPL), and another 10 states have set eligibility above 200% as of January 2000 (HCFA, 2000a).
- Fifty states expanded Medicaid eligibility for children ages 6 to 15, 49 states expanded eligibility for children ages 1 to 5, and 45 states expanded eligibility for infants (Ullman et al., 1999).
- As a result of CHIP increasing the Medicaid threshold for income eligibility, the national average of income eligibility for Medicaid rose by approximately 80% (Ullman et al., 1999).
- To promote a new image for public insurance, 16 states call their programs CHIP, seven have used a state name or symbol (e.g., Hoosier Healthwise, PeachCare, BadgerCare, SoonerCare), five call their programs KidCare, two have Healthy Kids programs, and the other states have a variety of names (e.g., Husky, Healthwave) (NGA-NCSL, 1999).
- Eighteen states have 12-month continuous eligibility for CHIP, and 14 states have 12-month continuous eligibility for Medicaid (Cox and Cohen Ross, 2000). Continuous eligibility means that once a child is determined to be eligible, he or she remains enrolled in the program regardless of fluctuations in income.
- Five states (Connecticut, Massachusetts, Michigan, New Jersey, New York) have presumptive eligibility for CHIP, and seven states (Connecticut, Massachusetts, Nebraska, New Hampshire, New Jersey, New Mexico, New York) have presumptive eligibility for Medicaid (NGA-NCSL, 1999). This means that children who are presumed to be eligible can be temporarily enrolled immediately by an authorized person, pending a formal review. Thus, children can receive services right away and providers are assured of payment for those services.

Outreach

- Every state has involved schools and health care providers in outreach efforts (NGA-NCSL, 1999).
- Nearly every state has used a combination of radio, television, and print media to publicize CHIP (NGA-NCSL, 1999).
- Every state but Wyoming has a toll-free hotline (NGA-NCSL, 1999).
- All but three states (North Dakota, Washington, Wyoming) have forms that are four pages or less in length (NGA-NCSL, 1999).
- All but five states (Arkansas, Tennessee, Texas, Washington, Wyoming) have mail-in or fax-in applications (NGA-NCSL, 1999).
- The only states with asset tests for CHIP are Arkansas, Idaho, Missouri, and Oregon (Cox and Cohen Ross, 2000).
- Thirty-nine states have "family-friendly Web sites" with consumer-oriented enrollment information (NGA-NCSL, 2000), but only eight states (Arizona, California, Florida, Georgia, New York, Ohio, Oregon, and Pennsylvania) post total enrollment figures on their Web sites (CDF, 2000).
- Eligibility workers are outstationed in every state except Nevada, Oregon, Washington, and Wyoming (NGA-NCSL, 1999).
- Thirty-two states have involved the business community (NGA-NCSL, 1999).
- Ten states are funding community-based organizations to do outreach (NGA-NCSL, 1999).

Coverage

- Forty-three states provide a comprehensive, child-appropriate benefits package with the same types of benefits covered by Medicaid, although the benefits may be limited in some way (e.g., transportation may be covered for emergencies but not for routine medical visits). Virginia uses Medicaid benefits plus substance abuse services. California's Medi-Cal (Medicaid) expansion has Medicaid benefits, while its CHIP program (Healthy Families) uses the state employees' benchmark plan plus vision and dental services. Arizona, Delaware, Montana, and Utah use the state employees' benefit package as the benchmark, and Colorado uses the standard plan outlined by the state's small group insurance reform law. New York, Pennsylvania, and Florida kept the benefits from their pre-CHIP state-designed programs (NGA-NCSL, 1999), although New York added dental, vision, speech and hearing, durable medical equipment, and other benefits to make the program comparable to Medicaid managed care, and Florida added behavioral health benefits.

TABLE 5

State Variations in Dental Benefits

State	Preventive	Basic	X-Rays	Emergency/ Surgery	Orthodontics	Copayments and Caps	Comments
Alabama	●	●	N/S	N/S	◗	$5 for basic and major services. None for preventive and diagnostic.	● Comprehensive ◗ Some restrictions apply ○ Very limited or none N/S Not Specified
Arizona	●	●	N/S	◗	N/S	$1 for office visit, $5 non-emergency surgery and $5 non-emergency use of ER.	
Arkansas	●	●	◗	◗	N/S	$10 copayment except for dental preventive and diagnostic services.	
California	●	●	N/S	N/S	N/S	$5 for non-preventive services.	
Colorado	○	○	○	○	○		Legislature has passed but has not yet funded separate dental program.
Connecticut	●	●	●	●	◗	Various copayments apply to crowns, bridges, root canals, dentures, extractions and orthodontia.	
Delaware	○	○	○	○	○		
Florida*	○	○	○	○	○		*Florida CHIP program only offers dental benefits to children covered by Medicaid expansion and phase II. Florida Healthy Kids, phase II children are not offered dental care. However, county health plans and steering committees may elect to offer limited dental services as part of a state-only supported program.
Georgia	●	◗	◗	◗	◗	None	
Illinois	●	●	●	●	●	None	
Indiana	●	●	●	●	●	Families' copayments for the separate CHIP program will be on a sliding scale based on income levels.	
Iowa	●	●	●	◗	N/S	None	
Kansas	◗	◗	◗	●	N/S	None	
Kentucky*	●	●	●	●	N/S	No copayments on preventive service. $5 on intervention and emergency services.	*Kentucky's separate state program has been approved, but the state is currently implementing Title XXI as a Medicaid expansion.

(Continued next page)

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State Variations in Dental Benefits (continued)

State	Preventive	Basic	X-rays	Emergency Surgery	Orthodontics	Copayments and Caps	Comments
Maine	●	●	●	●	◗	None	
Maryland	●	●	●	●	◗	N/S	
Massachusetts	●	●	●	●	●	N/S	
Michigan	●	●	●	◗	N/S	Maximum services of $600 per year.	
Mississippi	●	●	●	◗	○	N/S	
Montana*							*Montana: Benchmark equivalent CHIP program based on State Employees Health Benefit Plan for children through age 18 to 150% of FPL.
New Hampshire	●	●	●	◗	○	Maximum services of $500 per year.	
New Jersey	●	●	●	N/S	N/S	$5 for visits, except preventive. No copayment for families below 150% of FPL.	
New York	●	●	●	◗	○	None	
North Carolina	●	●	●	●	N/S	$5 for visits, except preventive. No copayments for families below 150% of FPL.	
North Dakota	●	●	●	●	○	Copayments required for emergency services and prescriptions.	
Oregon*							*All services that are medically necessary as listed on the Oregon Health Plan Prioritized List. Some services require prior authorization.
Pennsylvania	●	●	●	N/S	N/S	None	
Texas	◗	◗	◗	◗	◗	N/S	
Utah	●	●	●	N/S	N/S	N/S	
Vermont	●	●	●	●	●	$10 per office visit.	
Virginia	●	●	●	◗	◗	N/S	
Washington	●	●	●	●	●	Premiums and copayments required but not specified.	
West Virginia	●	●	●	●	N/S	N/S	
Wisconsin	●	●	●	●	N/S	N/S	
Wyoming	●	●	●	●	◗	N/S	

● Comprehensive
◗ Some restrictions apply
○ Very limited or none
N/S Not Specified

Source: CDF analysis of state CHIP plans.

Includes only those states with separate state programs and combination plans. All others have dental benefits through EPSDT.

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- Out of 29 non-Medicaid CHIP plans (states with separate plans and combination programs), every one includes prescription drug coverage, inpatient and outpatient mental health services, and outpatient substance abuse services, although most benefits have some restrictions (U.S. GAO, 2000). Every state, except Montana, covers durable medical equipment and physical and occupational therapy (NGA-NCSL, 1999).
- Every state except Delaware includes dental coverage in its CHIP program. However, coverage varies significantly from state-to-state (see Table 5).
- Case management services are included in 18 non-Medicaid CHIP plans. These services are particularly important for children with special health care needs.

Strategic Objectives and Performance Goals

By law, states must set strategic objectives and performance goals for measuring CHIP's effects on the extent of coverage.

- Of 29 states with non-Medicaid CHIP plans, 18 plan to measure the percentages of insured and uninsured children, and 14 have specific enrollment targets. Colorado and Virginia are the only states that have chosen to report performance in both areas (NGA-NCSL, 1999).
- To measure access to care, 14 states plan to report the percentage of CHIP children with a usual source of care, and seven states plan to report the number of children with an assigned primary care provider (NGA-NCSL, 1999).

To ensure that they receive accurate numbers on health care services, states must include specifications in their contracts with providers for the information they want to report. The first state reports were due to HCFA by March 31, 2000, but because of delays in many states' submissions, these data are not available for inclusion in this report.

TABLE 6

Low-Income Uninsured Children and CHIP

	Target: Uninsured Children Under 19 At or Below 200% of Federal Poverty Level			Type of CHIP Program*	Total Children Ever Served by CHIP in FY 1999	Date of CHIP Implementation
	Number	Percentage of All Children in State	State Rank			
Alabama	154,000	12.9	43	C	38,980	2/1/98
Alaska	11,000	5.3	6	M	8,033	3/1/99
Arizona	190,000	13.8	47	S	26,807	11/1/98
Arkansas	92,000	12.8	42	M	913	10/1/98
California	1,281,000	13.1	45	C	222,351	3/1/98
Colorado	72,000	6.4	16	S	24,116	4/22/98
Connecticut	53,000	6.3	13	C	9,912	7/1/98
Delaware	13,000	6.6	21	S	2,433	2/1/99
District of Columbia	16,000	13.7	46	M	3,029	10/1/98
Florida	444,000	11.5	41	C	154,594	4/1/98
Georgia	214,000	9.7	37	S	47,581	11/1/98
Hawaii	13,000	4.0	2	M	NI	7/1/00
Idaho	31,000	8.0	30	M	8,482	10/1/97
Illinois	211,000	6.1	11	M	42,699	1/5/98
Indiana	131,000	8.0	31	C	31,246	10/1/97
Iowa	67,000	8.6	35	C	9,795	7/1/98
Kansas	60,000	8.0	29	S	14,443	1/1/99
Kentucky	93,000	8.6	33	C	18,579	7/1/98
Louisiana	194,000	14.6	48	M	21,580	11/1/98
Maine	24,000	7.6	26	C	13,657	7/1/98
Maryland	100,000	7.1	23	M	18,072	7/1/98
Massachusetts	69,000	4.4	3	C	67,852	10/1/97
Michigan	156,000	5.7	9	C	26,652	5/1/98
Minnesota	50,000	3.7	1	M	21	10/1/98
Mississippi	110,000	13.1	44	C	13,218	7/1/98
Missouri	97,000	6.4	17	M	49,529	9/1/98
Montana	24,000	9.6	36	S	1,019	1/1/99
Nebraska	30,000	6.3	12	M	9,713	5/1/98
Nevada	43,000	8.6	34	S	7,802	10/1/98
New Hampshire	20,000	6.3	14	C	4,554	5/1/98
New Jersey	134,000	6.3	15	C	75,652	3/1/98
New Mexico	117,000	21.1	51	M	4,500	3/31/99
New York	399,000	8.2	32	C	521,301	4/15/98
North Carolina	138,000	6.6	20	S	57,300	10/1/98
North Dakota	10,000	5.7	8	C	266	10/1/98
Ohio	205,000	6.7	22	M	83,688	1/1/98
Oklahoma	170,000	17.6	50	M	40,196	12/1/97
Oregon	67,000	7.4	24	S	27,285	7/1/98
Pennsylvania	200,000	6.5	18	S	81,758	5/28/98
Rhode Island	19,000	7.5	25	M	7,288	10/1/97
South Carolina	110,000	10.4	39	M	45,737	10/1/97
South Dakota	17,000	7.8	27	M	3,191	7/1/98
Tennessee	115,000	7.9	28	M	9,732	10/1/97
Texas	1,031,000	16.7	49	C	50,878	7/1/98
Utah	46,000	6.0	10	S	13,040	8/3/98
Vermont	7,000	4.6	4	S	2,055	10/1/98
Virginia	118,000	6.5	19	S	16,895	10/22/98
Washington	85,000	5.3	7	S	NI	2/1/00
West Virginia	45,000	10.1	38	C	7,957	7/1/98
Wisconsin	75,000	5.2	5	M	12,949	4/1/99
Wyoming	15,000	10.5	40	S	NI	12/1/99
United States	**7.2 million**	—	—	—	**2 million**	—

* M=Medicaid expansion; S=separate state program; C=combination of separate program and Medicaid expansion
NI = not implemented as of September 30, 1999 (FY 1999)

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NOTES:

Uninsured Children with Family Incomes At or Below 200% of Federal Poverty Level:
The Bureau of the Census estimated this number for the purpose of determining the states' funding allotments; numbers were based on the March 1994, 1995, and 1996 Current Population Surveys, as adjusted in August 1998. The Children's Defense Fund (CDF) chose to use this set of numbers rather than more recent numbers because these were the numbers that the original and current state allotments are based on, and these numbers represent the target population at the initiation of the CHIP program. CDF calculated the percentage of uninsured children at or below 200% of FPL in each state by dividing the Census number by the July 1, 1998 Census state population estimates of children through age 18.
SOURCES: 1) Health Care Financing Administration., *State Children's Health Insurance Program: Reserved Allotments to States for Fiscal Year 1999* and *Revised Reserved Allotments to States for Fiscal Year 1998*. Federal Register, Vol 64, No.25: Monday, Feb. 8, 1999, pp. 6102-6108. 2) Bureau of the Census: July 1, 1998 state population estimates, adjusted for the undercount.

State Rank:
In this table, states are ranked from best (1) to worst (51) based on the percentage of children in the state who are at or below 200% of FPL and uninsured.

Type of CHIP Program:
Under the law creating CHIP, states are offered three options: they may expand coverage available under Medicaid (noted with an M), create a separate children's health insurance program (S), or combine both strategies (C).
SOURCE: Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report. October 1, 1998 - September 30, 1999*. Available at www.hcfa.gov. Accessed on 4/14/00.

Total Children Ever Served by CHIP in FY 1999:
Represents the formal state quarterly electronic statistical data submissions to HCFA and estimates, by states, in cases where the quarterly submissions were not available. The FY 1999 enrollment statistics reflect the unedited, unduplicated data as submitted by the states to HCFA.
SOURCE: Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report. October 1, 1998 - September 30, 1999*. Available at www.hcfa.gov. Accessed on 4/14/00.

Date of CHIP Implementation:
Represents the implementation date of the initial plan, as reported by the states to HCFA.
SOURCE: Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report. October 1, 1998 - September 30, 1999*. Available at www.hcfa.gov. Accessed on 4/14/00.

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"Of the 2 million children enrolled in CHIP by the end of September 1999, more than 1.2 million children were enrolled in separate programs, and nearly 700,000 were enrolled in Medicaid expansions."

Enrollment: Ranking State Progress

Of the 2 million children enrolled in CHIP by the end of September 1999, more than 1.2 million children were enrolled in separate programs, and nearly 700,000 were enrolled in Medicaid expansions (HCFA, 2000a). In order to compare states' progress thus far, CDF used the most current official data from HCFA on CHIP (FY 1999) and Medicaid enrollment (FY 1997 and 1998) to rank state progress.

CDF ranked state progress in two ways: CHIP enrollment alone and CHIP and Medicaid enrollment combined. First, we set a target number of uninsured children for each state, and we calculated the states' average monthly rates of progress toward covering the target number. We then ranked the average monthly progress rates from highest to lowest. These rankings provide a consistent way to compare state progress in increasing health coverage, regardless of plan size, design, scope, or months in operation.

To set the target number for each state, we used the estimated number of uninsured children at or below 200% of the Federal Poverty Level (FPL) (see Table 6). For each state, the target was based on the number of uninsured children when the CHIP program began, according to the Census Bureau's Current Population Survey. We chose 200% of FPL as the target number or goal because it represents the target population of uninsured children at the beginning of CHIP and because it was one of the factors used in setting the state funding allotments for CHIP. We then calculated the states' average monthly rates of progress toward covering the target number, using FY 1999 CHIP enrollment figures and the total number of months the CHIP program had been operating. Then, we ranked the states' progress in CHIP by their average monthly progress rates (Table 7).

Hawaii, Washington, and Wyoming are not ranked because they did not implement CHIP programs until after FY 1999. Minnesota is not ranked because it already had a children's Medicaid expansion at a very high eligibility level before CHIP. As a result, only a very small number of children in Minnesota are CHIP-eligible.

TABLE 7

State Rankings: Progress Under CHIP

State Rank: Percent Progress per Month Toward Target	State (Ordered by Rank)	Total Children Ever Served by CHIP in FY 1999	Number of Months Program in Operation	Percent Progress per Month Toward Target
1	Alaska	8,033	7	10.43
2	New York	521,301	18	7.26
3	Massachusetts	67,852	24	4.10
4	Missouri	49,529	13	3.93
5	Maine	13,657	15	3.79
6	North Carolina	57,300	12	3.46
7	New Jersey	75,652	19	2.97
8	Wisconsin	12,949	6	2.88
9	Oregon	27,285	15	2.71
10	Kansas	14,443	9	2.67
11	Pennsylvania	81,758	16	2.55
12	Vermont	2,055	12	2.45
13	Delaware	2,433	8	2.34
14	Georgia	47,581	11	2.02
14	Utah	13,040	14	2.02
16	Colorado	24,116	17	1.97
17	Ohio	83,688	21	1.94
18	Florida	154,594	18	1.93
19	Nebraska	9,713	17	1.90
20	South Carolina	45,737	24	1.73
21	Rhode Island	7,288	24	1.60
22	District of Columbia	3,029	12	1.58
23	Nevada	7,802	12	1.51
24	New Hampshire	4,554	17	1.34
25	Kentucky	18,579	15	1.33
26	Virginia	16,895	11	1.30
27	Arizona	26,807	11	1.28
28	Alabama	38,980	20	1.27
29	Connecticut	9,912	15	1.25
29	South Dakota	3,191	15	1.25
31	Maryland	18,072	15	1.20
32	West Virginia	7,957	15	1.18
33	Idaho	8,482	24	1.14
34	Oklahoma	40,196	22	1.07
35	Louisiana	21,580	11	1.01
36	Michigan	26,652	17	1.00
37	Indiana	31,246	24	0.99
38	Iowa	9,795	15	0.97
39	Illinois	42,699	21	0.96
40	California	222,351	19	0.91
41	Mississippi	13,218	15	0.80
42	New Mexico	4,500	6	0.64
43	Montana	1,019	9	0.47
44	Tennessee	9,732	24	0.35
45	Texas	50,878	15	0.33
46	North Dakota	266	12	0.22
47	Arkansas	913	12	0.08
—	Hawaii*	NI	—	—
—	Washington*	NI	—	—
—	Wyoming*	NI	—	—
—	Minnesota**	—	—	—

* States with NI had not implemented the program by the end of FY 1999.

** Minnesota's CHIP enrollment can not be compared with other states. The number of uninsured children eligible for CHIP in Minnesota is extremely small because the state made pre-CHIP Medicaid expansions with eligibility levels far higher than most other states' CHIP programs.

NOTES:

State Rank:
States were ranked from best (1) to worst (47) based on the rate of progress per month in covering uninsured children at or below 200% of the Federal Poverty Level (FPL) through CHIP.

Total Children Ever Served by CHIP in FY 1999
Represents the formal state quarterly electronic statistical data submissions to HCFA and estimates by states in cases where the quarterly submissions were not available.
The FY 1999 enrollment statistics reflect the unedited, unduplicated data as submitted by the states to HCFA.

SOURCE: Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report. October 1, 1998 - September 30, 1999.* Available at www.hcfa.gov. Accessed on 4/14/00.

Number of Months Program in Operation and Percent Progress per Month Toward Target
As a measure of progress toward covering the target number of children, the number of children ever served by CHIP in FY 1999 was divided by the number of uninsured children in the state at or below 200% of FPL. Progress toward covering the target number of uninsured children was adjusted for the number of months from the initial implementation date (rounded to the closest month) until the end of the reporting period in the enrollment report, September 30, 1999.

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As a result of the 1996 welfare law, enrollment in "regular" Medicaid has been fluctuating in recent years (Table 8). For example, the U.S. General Accounting Office (1999) reported that about 1.7 million adults and children lost Medicaid between 1995 and 1997. In a study of CHIP and Medicaid, Families USA (1999) found that children's enrollment in Medicaid dropped by almost 1 million (8.9%) between 1996 and 1999 in the 12 states with the largest number of uninsured children.

For our second set of rankings, we added the CHIP and Medicaid enrollment numbers together and calculated an average monthly progress rate for each state, based on the number of months the CHIP program was in operation (see Table 9). Then, we ranked states according to their progress on enrollment in CHIP and Medicaid combined. Table 10 combines the two sets of rankings to give an overall picture of state progress.

Our calculations provide a consistent way to compare state progress in increasing health insurance coverage because the rankings show enrollment as a proportion of the target number of uninsured children. The average monthly progress rate is a consistent way to measure performance while adjusting for the different lengths of time the CHIP programs have been operating in different states.

The average monthly progress rate also reflects intensity of efforts to enroll children. For example, Alaska implemented its program relatively late but enrolled a significant number of children per month and was approaching the target (percentage of eligible children at or below 200% of FPL). Alaska, therefore, ranks higher than states that have been in operation longer but enrolled a lower proportion of eligible children per month.

Top 10 States: CHIP and Medicaid Combined

- The top 10 states in increasing children's coverage through CHIP and Medicaid are Alaska, Massachusetts, Maryland, New York, Louisiana, Maine, Missouri, Nebraska, North Carolina, and Arkansas. Together, these states enrolled almost 1.1 million children.
- The top states are located all over the country: New England, Mid-Atlantic, South, Midwest, and West.
- The distribution of plan designs includes six Medicaid expansions (Alaska, Arkansas, Louisiana, Maryland, Missouri, Nebraska), three combination programs (Massachusetts, Maine, New York), and one separate state program (North Carolina).

TABLE 8

Changes in "Regular" Medicaid Enrollment of Children, 1997 to 1998

State	Children Ever Enrolled In: FY 1998	FY 1997	Total Change in Enrollment, FY 1997 to FY 1998	Percent Change in Enrollment
Alabama	326,400	319,803	6,597	2.1
Alaska	47,257	45,046	2,211	4.9
Arizona	359,687	372,568	-12,881	-3.5
Arkansas	185,051	146,831	38,220	26.0
California	3,093,098	3,206,566	-113,468	-3.5
Colorado	158,182	161,402	-3,220	-2.0
Connecticut	198,388	193,481	4,907	2.5
Delaware	51,057	51,165	-108	-0.2
District of Columbia	65,697	69,888	-4,191	-6.0
Florida	1,002,737	1,064,892	-62,155	-5.8
Georgia	680,791	680,136	655	0.1
Hawaii	75,329	n/a	—	—
Idaho	65,776	64,150	1,626	2.5
Illinois	821,594	858,289	-36,695	-4.3
Indiana	337,737	320,444	17,293	5.4
Iowa	142,100	139,661	2,439	1.7
Kansas	124,514	132,113	-7,599	-5.8
Kentucky	282,190	288,270	-6,080	-2.1
Louisiana	350,492	248,030	102,462	41.3
Maine	86,689	81,961	4,728	5.8
Maryland	295,549	187,105	108,444	58.0
Massachusetts	463,804	352,124	111,680	31.7
Michigan	567,854	672,587	-104,733	-15.6
Minnesota	308,613	328,639	-20,026	-6.1
Mississippi	255,614	260,798	-5,184	-2.0
Missouri	421,830	420,222	1,608	0.4
Montana	44,416	47,056	-2,640	-5.6
Nebraska	120,392	110,356	10,036	9.1
Nevada	69,281	69,287	-6	0.0
New Hampshire	56,064	57,955	-1,891	-3.3
New Jersey	394,443	391,455	2,988	0.8
New Mexico	221,490	217,289	4,201	1.9
New York	1,488,919	1,556,791	-67,872	-4.4
North Carolina	621,126	619,402	1,724	0.3
North Dakota	28,972	29,987	-1,015	-3.4
Ohio	652,630	666,027	-13,397	-2.0
Oklahoma	n/a	n/a	—	—
Oregon	141,508	222,232	-80,724	-36.3
Pennsylvania	799,439	803,213	-3,774	-0.5
Rhode Island	65,263	64,496	767	1.2
South Carolina	310,020	278,253	31,767	11.4
South Dakota	45,742	46,435	-693	-1.5
Tennessee	546,545	595,401	-48,856	-8.2
Texas	1,547,176	1,651,692	-104,516	-6.3
Utah	115,434	114,619	815	0.7
Vermont	57,405	57,978	-573	-1.0
Virginia	360,013	376,740	-16,727	-4.4
Washington	515,912	504,161	11,751	2.3
West Virginia	182,281	194,384	-12,103	-6.2
Wisconsin	242,255	263,392	-21,137	-8.0
Wyoming	28,045	29,929	-1,884	-6.3

* 'n/a' indicates no data available for the state in that fiscal year.

NOTES:

Total Change in Enrollment: Calculated by comparing the enrollment of children in Medicaid in FY 1997 to that of FY 1998, the two most recent years of available data. Only those in the HCFA eligibility category of children were counted. Persons under 21 enrolled by virtue of pregnancy, disability, or some other eligibility category are therefore not included.

SOURCE: Health Care Financing Administration, HCFA-2082 Reports: August 16, 1999 and January 27, 2000. Available at www.hcfa.gov.

Percent Change in Enrollment: The total change in enrollment as a percentage of the FY 1997 enrollment.

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TABLE 9

Progress in CHIP and Medicaid Combined, FY 1999

	Number of Uninsured Children At or Below 200% of Federal Poverty Level	Change in Medicaid Enrollment: FY 1997-FY 1998	Total Children Ever Served by CHIP in FY 1999	Number of Months Program in Operation	Total New Coverage	Percent Progress per Month Toward Target	State Rank: Progress per Month (CHIP and Medicaid Combined)
Alaska	11,000	2,211	8,033	7	10,244	13.30	1
Massachusetts	69,000	111,680	67,852	24	179,532	10.84	2
Maryland	100,000	108,444	18,072	15	126,516	8.43	3
New York	399,000	-67,872	521,301	18	453,429	6.31	4
Louisiana	194,000	102,462	21,580	11	124,042	5.81	5
Maine	24,000	4,728	13,657	15	18,385	5.11	6
Missouri	97,000	1,608	49,529	13	51,137	4.06	7
Nebraska	30,000	10,036	9,713	17	19,749	3.87	8
North Carolina	138,000	1,724	57,300	12	59,024	3.56	9
Arkansas	92,000	38,220	913	12	39,133	3.54	10
New Jersey	134,000	2,988	75,652	19	78,640	3.09	11
South Carolina	110,000	31,767	45,737	24	77,504	2.94	12
Pennsylvania	200,000	-3,774	81,758	16	77,984	2.44	13
Delaware	13,000	-108	2,433	8	2,325	2.24	14
Utah	46,000	815	13,040	14	13,855	2.15	15
Georgia	214,000	655	47,581	11	48,236	2.05	16
Connecticut	53,000	4,907	9,912	15	14,819	1.86	17
Rhode Island	19,000	767	7,288	24	8,055	1.77	18
Vermont	7,000	-573	2,055	12	1,482	1.76	19
Colorado	72,000	-3,220	24,116	17	20,896	1.71	20
Ohio	205,000	-13,397	83,688	21	70,291	1.63	21
Indiana	131,000	17,293	31,246	24	48,539	1.54	22
Nevada	43,000	-6	7,802	12	7,796	1.51	23
Alabama	154,000	6,597	38,980	20	45,577	1.48	24
Idaho	31,000	1,626	8,482	24	10,108	1.36	25
Kansas	60,000	-7,599	14,443	9	6,844	1.27	26
New Mexico	117,000	4,201	4,500	6	8,701	1.24	27
Iowa	67,000	2,439	9,795	15	12,234	1.22	28
Florida	444,000	-62,155	154,594	18	92,439	1.16	29
Oklahoma	170,000	0	40,196	22	40,196	1.07	30
South Dakota	17,000	-693	3,191	15	2,498	0.98	31
Kentucky	93,000	-6,080	18,579	15	12,499	0.90	32
New Hampshire	20,000	-1,891	4,554	17	2,663	0.78	33
Arizona	190,000	-12,881	26,807	11	13,926	0.67	34
Mississippi	110,000	-5,184	13,218	15	8,034	0.49	35
California	1,281,000	-113,468	222,351	19	108,883	0.45	36
Illinois	211,000	-36,695	42,699	21	6,004	0.14	37
Virginia	118,000	-16,727	16,895	11	168	0.01	38
Texas	1,031,000	-104,516	50,878	15	-53,638	-0.35	39
District of Columbia	16,000	-4,191	3,029	12	-1,162	-0.61	40

(Continued on the next page)

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TABLE 9

Progress in CHIP and Medicaid Combined, FY 1999

	Number of Uninsured Children At or Below 200% of Federal Poverty Level	Change in Medicaid Enrollment: FY 1997-FY 1998	Total Children Ever Served by CHIP in FY 1999	Number of Months Program in Operation	Total New Coverage	Percent Progress per Month Toward Target	State Rank: Progress per Month (CHIP and Medicaid Combined)
West Virginia	45,000	-12,103	7,957	15	-4,146	-0.61	41
North Dakota	10,000	-1,015	266	12	-749	-0.62	42
Montana	24,000	-2,640	1,019	9	-1,621	-0.75	43
Tennessee	115,000	-48,856	9,732	24	-39,124	-1.42	44
Wisconsin	75,000	-21,137	12,949	6	-8,188	-1.82	45
Michigan	156,000	-104,733	26,652	17	-78,081	-2.94	46
Oregon	67,000	-80,724	27,285	15	-53,439	-5.32	47
Hawaii*	13,000	—	NI	—	—	—	—
Washington*	85,000	—	NI	—	—	—	—
Wyoming*	15,000	—	NI	—	—	—	—
Minnesota**	50,000	-20,026	—	12	—	—	—

* States with NI had not implemented the program by the end of FY 1999.

** Minnesota CHIP enrollment can not be compared with other states; the number of uninsured children eligible for CHIP in Minnesota is extremely small because the state expanded Medicaid for children before CHIP, setting eligibility levels far higher than most state CHIP programs.

NOTES:

Number of Uninsured Children At or Below 200% of the Federal Poverty Level (FPL):
The Bureau of the Census estimated this number for the purpose of determining the states' allotments; numbers were based on the March 1994, 1995, and 1996 Current Population Surveys, as adjusted in August 1998. CDF chose to use this set of numbers rather than more recent numbers because these were the numbers that the original and current state allotments are based on, and these numbers represent the target population at the initiation of the CHIP program.
SOURCES: Health Care Financing Administration, *State Children's Health Insurance Program; Reserved Allotments to States for Fiscal Year 1999* and *Revised Reserved Allotments to States for Fiscal Year 1998*. Federal Register, Vol 64, No.25: Monday, Feb. 8, 1999, pp. 6102-6108.

Change in Medicaid Enrollment:
Change in enrollment was calculated by comparing the enrollment of children in Medicaid in FY 1997 to that of FY 1998, the two most recent years of available data. Only those in the HCFA eligibility category of children were counted. Persons under 21 enrolled by virtue of pregnancy, disability, or some other eligibility category are therefore not included.
SOURCE: Health Care Financing Administration, *HCFA-2082 Reports: August 16, 1999* and *January 27, 2000*. Available at www.hcfa.gov.

Total Children Ever Served by CHIP in FY 1999:
Represents the formal state quarterly electronic statistical data submissions to HCFA and estimates, by states, in cases where the quarterly submissions were not available. The FY 1999 enrollment statistics reflect the unedited, unduplicated data as submitted by the states to HCFA.
SOURCE: Health Care Financing Administration, *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 - September 30, 1999*. Available at www.hcfa.gov. Accessed on 4/14/00.

Total New Coverage:
A combination of CHIP enrollment and Medicaid enrollment changes. Since Medicaid and CHIP comprise most of the direct efforts states can make toward reducing the number of uninsured children, the combination of these two programs represents how well these efforts are working.

Number of Months Program in Operation and Percent Progress per Month Toward Target:
As a measure of progress toward covering the target number of children, the change in Medicaid enrollment from FY 1997 to FY 1998 was added to the number of children ever served by CHIP in FY 1999, and this total was divided by the number of uninsured children in the state at or below 200% of FPL. Progress toward covering the target number of uninsured children was adjusted for the number of months the CHIP program had been in operation in the state, that is, the number of months from the initial implementation date (rounded to the closest month) until the end of the reporting period in the enrollment report, 9/30/99.
SOURCE: Health Care Financing Administration, *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 - September 30, 1999*. Available at www.hcfa.gov. Accessed on 4/14/00.

State Rank:
States were ranked from best (1) to worst (47) based on the rate of progress per month in covering uninsured children at or below 200% of FPL.

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- Months in operation range from seven (Alaska) to 24 (Massachusetts).
- New York has enrolled the largest number of children (453,000), followed by Massachusetts (180,000). Maryland and Louisiana have enrolled 127,000 and 124,000, respectively. Three states are in the 40,000 to 60,000 range (Arkansas, Missouri, North Carolina), two have 18,000 and 20,000 (Maine and Nebraska), and Alaska has 10,000 children enrolled. Together, these 10 states account for almost 1.1 million newly insured children (see Table 9).
- Maryland has increased its "regular" Medicaid enrollment by nearly 60%, and Massachusetts and Louisiana had increases in the 30% to 40% range. Arkansas had an increase of 26%, and Alaska, Maine, and Nebraska had increases of 4% to 9%. Missouri and North Carolina stayed about the same. New York was the only state in the top 10 that had a decrease in Medicaid enrollment (-4.4%).

Top 10 States: CHIP Alone

- Alaska, New York, Massachusetts, Missouri, Maine, North Carolina, New Jersey, Wisconsin, Oregon, and Kansas are at the top of the list in CHIP enrollment. Together, these states enrolled 848,000 children.
- Similar to the combination rankings, all regions of the country are represented.
- Four states have combination plans (Massachusetts, Maine, New Jersey, New York); three have Medicaid expansions (Alaska, Missouri, Wisconsin); and three have separate state programs (Kansas, North Carolina, Oregon).
- The programs have been in operation from seven to 24 months.
- Size varies. New York has the largest enrollment, having enrolled more than 520,000 children in Child Health Plus and the Medicaid expansion since April 1998. Four programs range from 27,000 to 76,000 children (Massachusetts, Missouri, North Carolina, New Jersey, Oregon), and four have fewer than 15,000 enrollees (Alaska, Kansas, Maine, Wisconsin).

TABLE 10

States' Net Increases in Insurance Coverage

	Type of CHIP Program*	Rank: CHIP Enrollment Only	Rank: Medicaid Changes and CHIP Enrollment	Total New Coverage
Alabama	C	28	24	45,577
Alaska	M	1	1	10,244
Arizona	S	27	34	13,926
Arkansas	M	47	10	39,133
California	C	40	36	108,883
Colorado	S	16	20	20,896
Connecticut	C	29	17	14,819
Delaware	S	13	14	2,325
District of Columbia	M	22	40	-1,162
Florida	C	18	29	92,439
Georgia	S	14	16	48,236
Hawaii	M	NR	NR	—
Idaho	M	33	25	10,108
Illinois	M	39	37	6,004
Indiana	C	37	22	48,539
Iowa	C	38	28	12,234
Kansas	S	10	26	6,844
Kentucky	C	25	32	12,499
Louisiana	M	35	5	124,042
Maine	C	5	6	18,385
Maryland	M	31	3	126,516
Massachusetts	C	3	2	179,532
Michigan	C	36	46	-78,081
Minnesota**	M	NR	NR	—
Mississippi	C	41	35	8,034
Missouri	M	4	7	51,137
Montana	S	43	43	-1,621
Nebraska	M	19	8	19,749
Nevada	S	23	23	7,796
New Hampshire	C	24	33	2,663
New Jersey	C	7	11	78,640
New Mexico	M	42	27	8,701
New York	C	2	4	453,429
North Carolina	S	6	9	59,024
North Dakota	C	46	42	-749
Ohio	M	17	21	70,291
Oklahoma	M	34	30	40,196
Oregon	S	9	47	-53,439
Pennsylvania	S	11	13	77,984
Rhode Island	M	21	18	8,055
South Carolina	M	20	12	77,504
South Dakota	M	29	31	2,498
Tennessee	M	44	44	-39,124
Texas	C	45	39	-53,638
Utah	S	14	15	13,855
Vermont	S	12	19	1,482
Virginia	S	26	38	168
Washington	S	NR	NR	—
West Virginia	C	32	41	-4,146
Wisconsin	M	8	45	-8,188
Wyoming	S	NR	NR	—

* M=Medicaid expansion; S=separate state program; C=combination of separate program and Medicaid expansion, according to HCFA

** Minnesota CHIP enrollment can not be compared with other states; the number of uninsured children eligible for CHIP in Minnesota is extremely small due to the state's Medicaid expansion in place before CHIP with eligibility levels far higher than most state CHIP programs.

NR= not ranked

NOTES:

Rank:
CHIP Enrollment Only: States were ranked from best (1) to worst (47) based on the average monthly progress rate toward covering children at or below 200% of FPL, based on CHIP enrollment alone.

Medicaid Changes and CHIP Enrollment: States were ranked from best (1) to worst (47) based on the rate of progress per month in covering uninsured children at or below 200% of FPL using combined data from Medicaid and CHIP.

Total New Coverage:
A combination of CHIP enrollment and Medicaid enrollment changes. Since Medicaid and CHIP comprise most of the direct efforts states can make toward reducing the number of uninsured children, the combination of these two programs represents how well these efforts are working.

SOURCES:
1) Health Care Financing Administration. *State Children's Health Insurance Program; Reserved Allotments to States for Fiscal Year 1999 and Revised Reserved Allotments to States for Fiscal Year 1998.* Federal Register, Vol 64, No.25: Monday, Feb. 8, 1999, pp. 6102-6108.
2) Health Care Financing Administration. *HCFA-2082 Reports: August 16, 1999 and January 27, 2000* (Available at www.hcfa.gov).
3) Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report. October 1, 1998 September 30, 1999* (Available at www.hcfa.gov).

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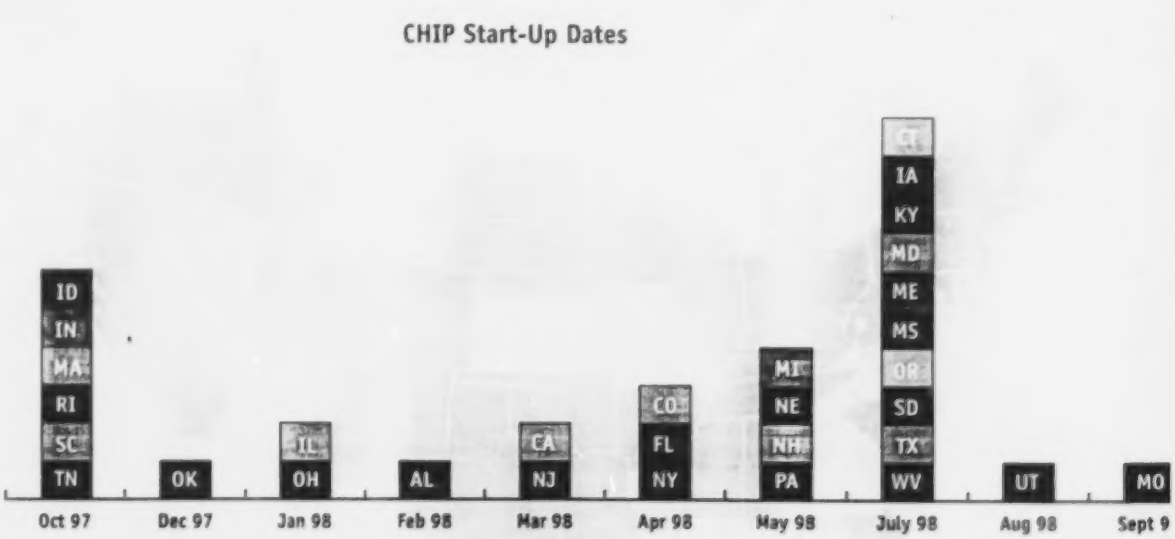
Additional Observations

- Of the states with the largest *number* of uninsured children before CHIP, California (40th) and Texas (45th) were ranked in the bottom 10 states for CHIP programs. In both states, the majority of uninsured children (about six out of 10) are Hispanic. Texas also fell into the bottom 10 (39th) on the combined rankings for CHIP and Medicaid programs.
- Although California has provided new insurance for the second largest *number* of children under CHIP (222,351), the state's progress represents less than 20% of the target number of uninsured children in the state.

FIGURE 2



Source: Health Care Financing Administration. *The State Children's Health Insurance Program Annual Enrollment Report. October 1, 1998-September 30, 1999.* Available at www.hcfa.gov. Accessed on 4/4/00.

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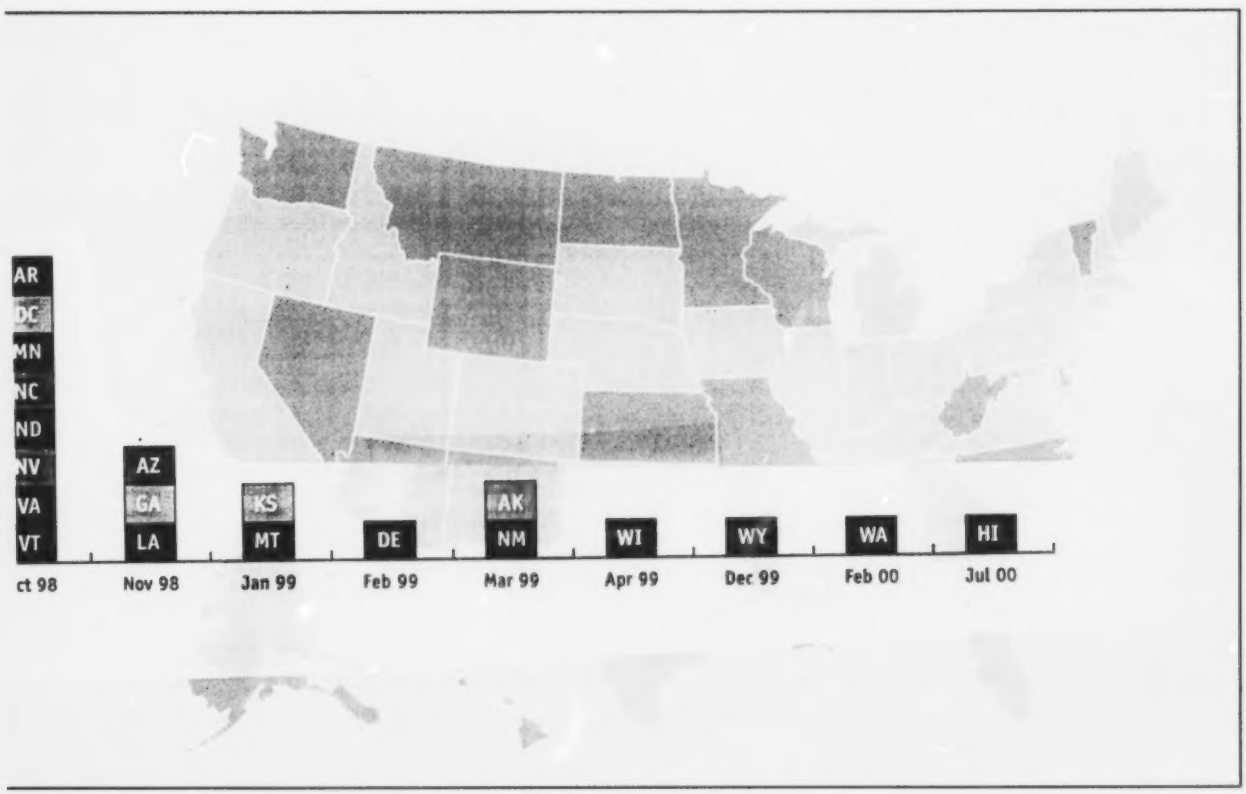
- Among the 11 states with the largest *percentages* (11% or higher) of uninsured children at or below 200% of FPL before CHIP (Alabama, Arizona, Arkansas, California, District of Columbia, Florida, Louisiana, Mississippi, New Mexico, Oklahoma, Texas), Texas and the District of Columbia both lost ground, with increases in the numbers of uninsured children.
- In the combined rankings, Louisiana was 5th and Arkansas was 10th because of increases in Medicaid enrollment of 41% and 26%, respectively.



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First, I feel really stressed. Then, I give him an aspirin. I try to go through everything first: hot tea, over-the-counter remedies like Alka-Seltzer Plus, laxatives. Then I get angry that he got sick in the first place. Then I get depressed worrying that he may be seriously ill. Then I gather my courage in case I have to take him to the hospital. I hardly ever go to the emergency room, but if my child is really sick, I'll go.

A Mississipi grandmother caring for her 15-year-old grandson,
Participant in focus group conducted for CDF by
Fallon McElligott, 1998

The Policy Context: Next Steps for CHIP

OVERVIEW OF PERFORMANCE UNDER CHIP AND MEDICAID, 1997-1999

At the time CHIP was created, an estimated 11.3 million children were uninsured. The most recent national figures show that the number of uninsured children has increased to almost 12 million, primarily because so many children wrongfully lost Medicaid coverage as a result of the 1996 welfare law. These figures are based on insurance coverage in 1998, so they do not reflect CHIP enrollment thus far.

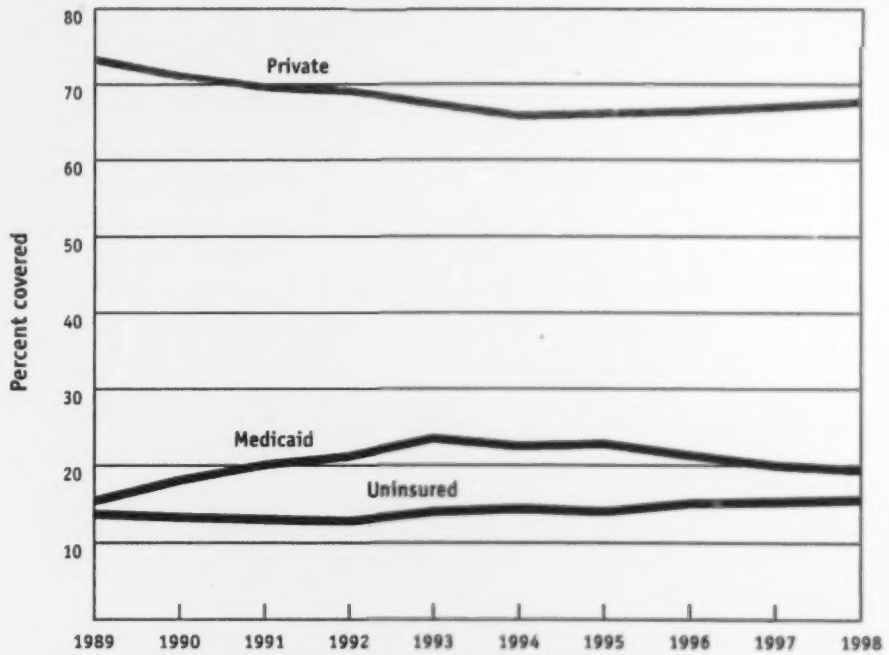
Changes in both the public and private sectors will influence the long-term impact of CHIP on children's insurance coverage. During the early 1990s, the gradual decline in the percentage of privately insured children was partially offset by increases in Medicaid enrollment (Edmunds and Coye, 1998a).

In the late 1990s, the trend changed: Medicaid enrollment declined because of welfare reform. In the private sector, the percentage of insured children stayed about the same among higher-income families with coverage through large employers (Fronstin, 1999), but it dropped by 5% for lower-income working families and children (Center for Studying Health System Change, 2000; Gabel et al., 1999b).

CHIP was intended to bridge the insurance gap for low-income working families who earn too much to qualify for Medicaid but can not afford private coverage. Because changes in other key sources of coverage will affect the long-term impact of CHIP, its effectiveness must be evaluated not just in terms of total enrollment but also in terms of its impact on the agencies that serve children. If CHIP encourages agencies and organizations to coordinate their eligibility and enrollment processes, CHIP will have made a significant contribution toward seamless systems of care and coverage for children.

TABLE 11

Trends in Children's Health Coverage, 1989 to 1998



Trends in Children's Health Coverage, 1989 to 1998

Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Number* private	49,803	48,776	48,260	48,638	49,293	48,672	49,444	49,761	50,556	51,441
Number* Medicaid	10,466	12,434	13,918	14,916	17,174	16,618	17,043	15,972	15,100	14,729
Number* uninsured	9,275	9,133	9,026	9,043	10,261	10,651	10,503	11,300	11,586	11,871

Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Percent private	73.3	71.1	69.6	69.1	67.4	65.8	66.1	66.4	67.0	67.7
Percent Medicaid	15.4	18.1	20.1	21.2	23.5	22.5	22.8	21.3	20.0	19.4
Percent uninsured	13.7	13.3	13.0	12.8	14.0	14.4	14.0	15.1	15.3	15.6

* Numbers are in thousands. Children are ages 0 to 18. The percentage of uninsured children in 1997 and 1998 is approximately 0.1% higher than in previous years due to a change in the definition of children whose only coverage is through the Indian Health Service. Until 1997 (March 1998 Current Population Survey), such children were considered to be covered by Medicaid. Starting in 1997, these children were defined as uninsured.

SOURCES: U.S. Department of Commerce, Bureau of the Census, March 1990 through 1999 *Current Population Surveys*. Calculations by Health Division, Children's Defense Fund.

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Accountability for CHIP

The original CHIP legislation provided a general framework for federal and state accountability (Edmunds and Coye, 1998b), including state performance goals and a report by the Secretary of HHS to Congress in December 2001. In November 1999, Congress provided new funds for data collection, specified periodic audits by the Inspector General of HHS and the U.S. General Accounting Office, and directed HHS to take the lead on improving the quality of data (P.L. 106-113) (CDF, 2000).

HCFA (1998, 1999) provided written guidance and technical assistance to states over several months as the new law took effect, but the proposed rules for CHIP were not published until November 1999. In addition to implementing welfare reform and CHIP, HHS was also responsible for overhauling the national medical data reporting system under provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Atchinson and Fox, 1997), implementing new consumer protections under Medicaid managed care required by the Balanced Budget Act, addressing U.S. General Accounting Office reports on Medicaid drop-off, and developing new Medicaid reporting systems.

Because changes in other key sources of coverage will affect the long-term impact of CHIP, its effectiveness must be evaluated not just in terms of total enrollment but also in terms of its impact on the agencies that serve children.

What worries states, as they struggle with the implementation of this complicated program, is that their actions will be too quickly judged as a failure. The law poses some fundamental challenges for states that are worth noting. First, in the law, states are held to reducing the number of uninsured children. But that's an unfair test. We don't even have agreement on the number of uninsured kids. And we don't know what would have happened to the rate of uninsured kids absent CHIP, with a churning and changing marketplace, welfare reform, and other political and economic changes. That makes a reduction in the number of uninsured kids an awfully tough bar for states to meet.

Trish Riley, National Academy for State Health Policy,
in J. Feder and Sheila Burke (Eds.),
Options for Expanding Health Insurance Coverage:
A Report on a Policy Roundtable,
The Kaiser Project on Incremental Health Reform,
October 1999, p. 27

TABLE 12

Children's Health Insurance Coverage, 1998

All children (0 to 18)	76.0 million
Uninsured children	11.9 million
Percent uninsured	15.6 percent

Covered at any time during the year by:

	Number	Percent
Any insurance	64.1 million	84.4
Private only	51.4 million	67.7
Employer-based	48.0 million	63.2
Other private	3.4 million	4.5
Public	17.0 million	22.4
Medicaid only*	11.6 million	15.3
Medicare	0.3 million	0.5
CHAMPUS	2.4 million	3.1
Both Medicaid* and private	3.1 million	4.1
No insurance**	11.9 million	15.6

NOTES:

* Bureau of the Census notes that the number of children covered by Medicaid has been significantly underreported by the Current Population Survey in recent years. According to HCFA, 22.3 million children under age 21 (about 1 out of 4) had some Medicaid coverage in FY 1998.

** Children whose only health coverage is through the Indian Health Service are classified as uninsured.

Source: Bureau of the Census, March 1999 Current Population Survey, and HCFA 2082 data for FY 1998. Calculations by the Children's Defense Fund, November/December 1999.

Without specific reporting requirements in the original statute, federal officials and the research community were concerned about getting comparable data across states, and state officials were not sure how they would be evaluated. To address this concern, the National Academy for State Health Policy (NASHP), with support from the David and Lucile Packard Foundation, developed a template for CHIP reporting. NASHP actively collaborated with officials from the Health Care Financing Administration, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration, as well as with representatives of the National Governors' Association, the American Public Human Services Association, the Center on Budget and Policy Priorities, the Children's Defense Fund, the March of Dimes, and other groups (NASHP, 1999).

After being reviewed by dozens of researchers, state and federal officials, and advocates, the template was endorsed by HCFA and adopted by every state. This will make it much easier to assess the program on a national basis.

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States vary in their approaches to accountability, data collection, and federal reporting for Medicaid and CHIP (U.S. GAO, 1999; Iglehart, 1999). The administrative culture of an agency and its degree of reliance on information systems, its experience contracting for information from providers, and its connectivity to other state program databases will have a significant influence on the state's ability to report CHIP enrollment and programmatic information in real time. States with more advanced information technology systems may emerge as leaders in the national effort to provide timely information on CHIP and Medicaid enrollment.

States vary in their approaches to accountability, data collection, and federal reporting for Medicaid and CHIP.

HOW DID THEY DO IT?

California is the only state that provides weekly enrollment information on its CHIP program on a Web site. California's CHIP program, Healthy Families, is administered by the Medical Risk Medical Insurance Board (MRMIB), which was created in 1990 to oversee state-financed insurance expansions for low-income working families. Here are the steps that MRMIB took to make current data available to the public:

November 1997	Request for Proposals (RFP) for administrative vendor to process Healthy Families
January 1998	RFPs were due to MRMIB
March 15	State signed contract with administrative vendor
August 5	First data report provided to the MRMIB Board

The original RFP included a model contract with a description of the basic enrollment data that would be required (e.g., age, ethnicity, gender, county). MRMIB determined in advance what information would be needed for financial reasons, namely for paying the participating health plans, as well as for future reporting to HCFA. MRMIB also recognized the value of having information on who was enrolling and disenrolling in order to target outreach and related activities. The MRMIB Board has public meetings once a month and posts minutes from its meetings on the Web site as well.

Source: Interview with Rob Campbell, Deputy Director, MRMIB, January 1999.

CHIP CHRONOLOGY

August 1997	Title XXI of the Social Security Act is enacted as part of the Balanced Budget Act of 1997, authorizing a new State Children's Health Insurance Program (CHIP)
October 1997	CHIP funding becomes available to states
January 1998	Health Care Financing Administration (HCFA) sends a letter to states encouraging them to reduce the length and complexity of CHIP and Medicaid applications
January 1998	Alabama's Medicaid expansion program becomes the first CHIP plan approved by HCFA
June 1998	Institute of Medicine report calls for new federal and state accountability systems to provide consistent information to evaluate CHIP's impact on access to care
September 1998	HCFA sends a second letter to states encouraging them to simplify CHIP and Medicaid applications
November 1998	HCFA sends a letter to states encouraging joint applications, simpler application procedures, mail-in applications, and more efficient eligibility determination (e.g., eliminating asset tests)
May 1999	HHS Inspector General reports that applications and administrative processes are barriers to CHIP enrollment in many states
August 1999	The National Academy for State Health Policy (NASHP) releases a model CHIP reporting framework developed in collaboration with national organizations and federal and state officials and supported by the David and Lucile Packard Foundation

August 1999	HCFA awards a five-year, $4.2 million contract to Mathematica Policy Research, Inc., to evaluate CHIP programs in two phases: state-by-state descriptions and national comparisons of enrollment, expenditures, use of services, access to care; and quality of care in Medicaid expansions and separate state programs
September 1999	U.S. General Accounting Office (GAO) report finds significant variation in state efforts to enroll eligible individuals in Medicaid
October 1999	HCFA provides written guidance on evaluation information and gives states the option of using the NASHP framework
October 1999	Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), and the Packard Foundation award $9.1 million for studies to improve health care for children enrolled in CHIP and Medicaid
November 1999	Balanced Budget Refinement Act of 1999 directs the Secretary of HHS to conduct a new $10 million federal evaluation of CHIP using a sample of 10 states, due December 31, 2001, and includes other monitoring provisions
November 1999	HCFA proposes CHIP regulations in Notice of Proposed Rule Making
March 2000	Every state is required to submit an evaluation to HCFA by assessing the increase in the number of insured children, describing the characteristics of CHIP participants, analyzing the program's impact on participants, and recommending future systems changes
April 2000	HCFA requires states to restore Medicaid benefits to families who improperly lost coverage due to welfare reform
December 2001	Secretary of HHS to submit report on CHIP to Congress

Medicaid

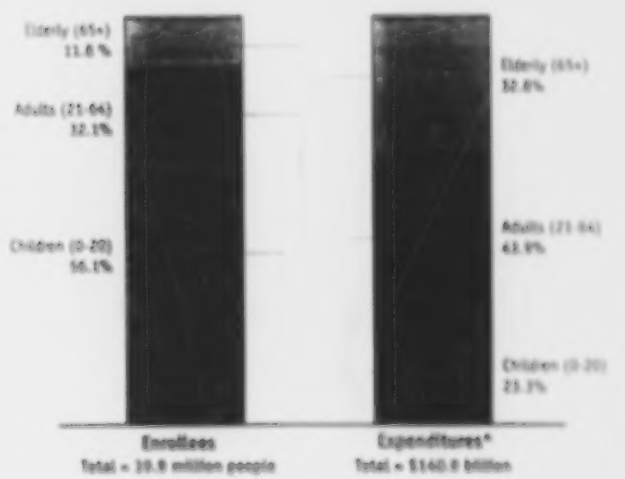
Medicaid is the largest single insurance program for American children. In 1998, Medicaid covered about 22 million, or one out of four children (HCFA, 2000b). Medicaid pays for nearly 30% of all visits to pediatricians (Yudkowsky et al., 1998), 38% of children's hospitalizations (AAP, 1999), and 30% to 40% of all U.S. births (AAP, 1999; NGA, 2000).

More than half of the Medicaid beneficiaries are children, but expenditures for children make up less than one-quarter of the total costs ($32.4 billion out of $140.9 billion in 1998) (see Figure 3). The average cost per child is $1,449 (including children with disabilities), a lower rate per person than any other age group (Figures 4 and 5) and only slightly more than the average estimated private-sector cost per child of $1,200 (AAP, 1998).

The number of children enrolled in Medicaid increased significantly from the early to late 1990s, rising from about 15 million in 1990 to 21 million in 1997 (Figure 6). These increases were due to Congressional expansions of eligibility in 1989 and 1990, requiring coverage for all children under five with incomes up to 133% of FPL and phasing in coverage for all children through age 18 up to 100% of FPL.

FIGURE 3

Children Make Up More Than Half of the Medicaid Participants But Have Less Than One-Quarter of the Costs



*Total expenditures exclude administrative expenses.
Source: Children's Defense Fund analysis of FY 1998 HCFA 2082 data.

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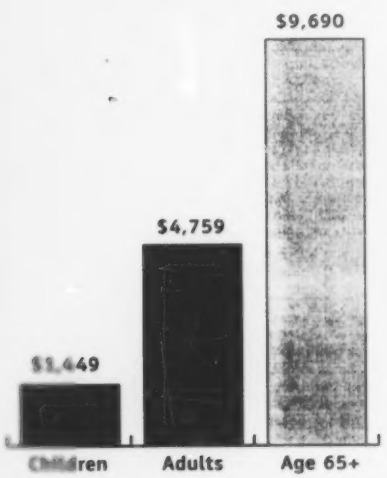
FIGURE 4

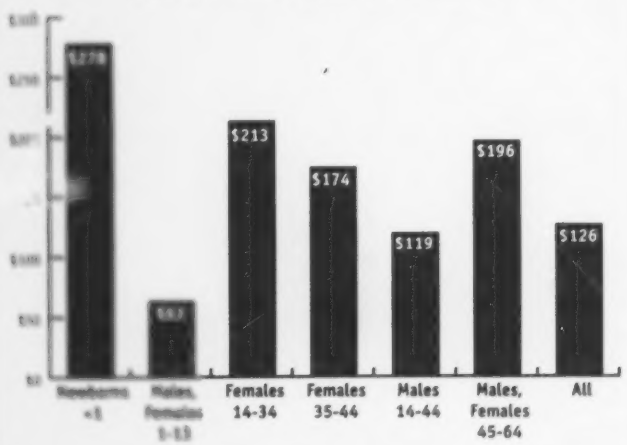
Children in Medicaid Cost Less Per Year Than Other Age Groups



All age groups include people with disabilities.
Source: Children's Defense Fund analysis of FY 1998 HCFA 2082 data.

FIGURE 5

Children Under 14 Have the Lowest Average Monthly Managed Care Payment Rate



Data: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey.
Source: Holahan J. et al., Medicaid Managed Care Payment Rates in 1998. *Health Affairs*, May/June 1999, 18(3):217-227.

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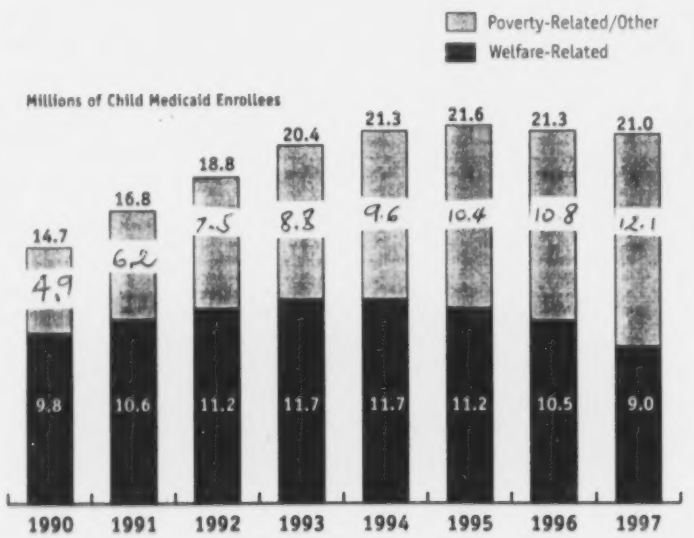
The Medicaid enrollment increases of the early- to mid-1990s were occurring at the same time that health care costs were rising across the country. States began to react to effects of Medicaid cost increases on state budgets by turning to some form of managed care. Large employers had chosen to reduce health care costs by moving employees into managed care, and states followed their example (Edmunds and Coye, 1998a).

Nationally, an estimated total of 40 million insured children are in some form of managed care (Simpson et al., 1998), including an estimated 11 million children in Medicaid managed care. The rapid growth in managed care has been accompanied by an increasing demand by private purchasers (employers) and public purchasers (states) for information on the performance of managed care plans in effectively providing care.

FIGURE 6

Enrollment of Children in Medicaid, 1990-1997



Source: Kaiser Commission on Medicaid and the Uninsured. *Key Facts: Health Coverage for Low-Income Children.* November 1999.

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Managed care can be problematic for children with special health care needs (Neff and Anderson, 1995; Newacheck et al., 2000b) if health plans and networks do not include an adequate number of specialists and subspecialists. Also, plans may not provide adequately for care management, medical equipment, and other needs of chronically ill children and those with disabilities. Health plans are beginning to offer disease management programs for asthma, diabetes, and other chronic conditions, but many advocates and family members feel the previous failures of health plans to provide adequate care for these children have not been fully addressed.

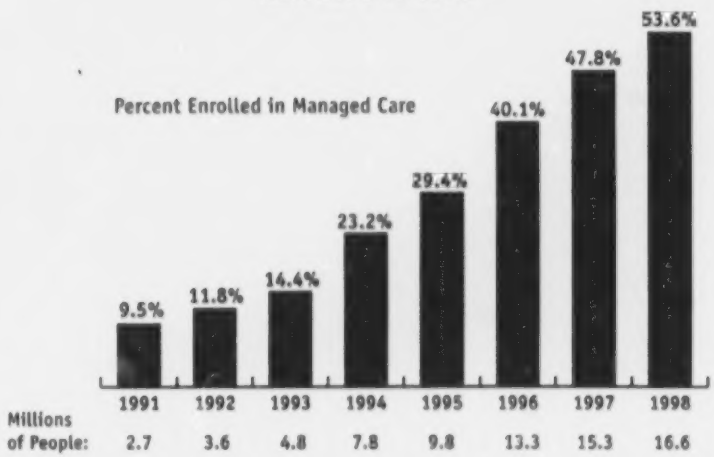
"Large employers chose to reduce health care costs by moving employees into managed care, and states followed their example."

In view of the billions of dollars that are being paid prospectively to managed care plans and the questions about the degree to which managed care is meeting the health needs of Medicaid beneficiaries, there is a new demand for public accountability.

U.S. General Accounting Office,
Medicaid Managed Care Accountability, May 16, 1997, p. 20

FIGURE 7

Enrollment in Medicaid Managed Care Quintupled from 1991 to 1998



Source: Health Care Financing Administration (HCFA). *National Summary of Medicaid Managed Care Programs and Enrollment*, June 30, 1997 (accessed 1/7/99) and June 30, 1998 (accessed 12/21/99). Available at www.hcfa.gov/medicaid/trends98.htm.

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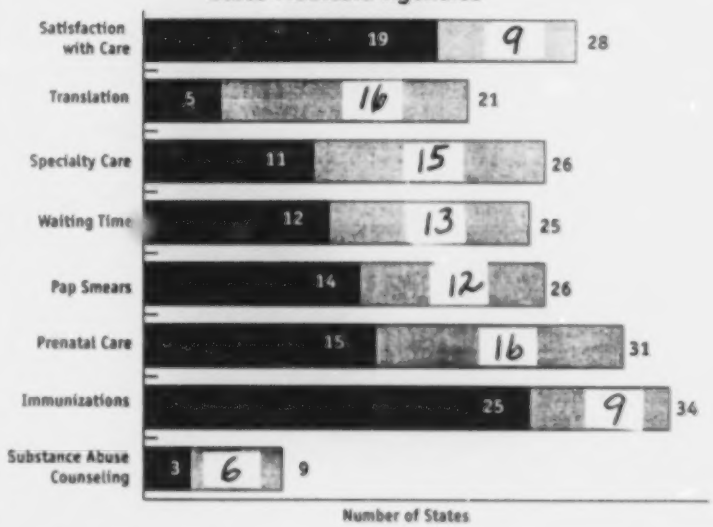
FIGURE 8

Use of Quality Measures in Managed Care by State Medicaid Agencies



Source: Landon BE, Tobias C, Epstein AM. Quality Management by State Medicaid Agencies Converting to Managed Care: Plans and Current Practice. *Journal of the American Medical Association*, 1998, 279:211-216.

Medicaid Managed Care

States have sought to control costs, improve efficiency of care, and increase access to preventive services for Medicaid enrollees through managed care. Enrollment in Medicaid managed care has quintupled since the early 1990s (Figure 7). By June 1998, more than half of all Medicaid beneficiaries — 16.6 million people, including approximately 11 million children — had been enrolled in some form of managed care. Comparable information on CHIP is not available yet.

For Medicaid and CHIP participants, states have increasingly turned to outside vendors to enroll families in managed care plans and to educate them about their options under managed care (Kaye, Pernice, and Pelletier, 1999). Managed care is a new experience for families who have never had health coverage before, and they need to become familiar with the way the system works. For example, they need to be encouraged to schedule well-child appointments in advance, or to use advice lines when a child is sick rather than visiting the emergency room.

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The rapid growth of managed care has raised many concerns about access to care, restrictions on the choice of providers, and the quality of care. There is tremendous variation from plan to plan, and from region to region, and studies tend to find mixed results.

For example, a recent national survey of 35,000 privately insured adults in managed care and other arrangements found comparable access to hospital care for both groups but found better access to preventive services, lower out-of-pocket costs, and lower satisfaction with physician visits among those enrolled in managed care (Center for Studying Health Systems Change, 2000).

"Managed care is a new experience for families who have never had health coverage before, and they need to become familiar with the way the system works."

Newcomers to managed care may not fully understand how the system operates to effectively access services, advocate on their own behalf, or register dissatisfaction with their plan or provider. This is especially true for individuals with diverse language and cultural needs.

U.S. General Accounting Office,
Medicaid Managed Care Accountability, May 16, 1997, p. 5

Accountability under Medicaid Managed Care

The same legislation that created CHIP also required HHS to develop new consumer protections for Medicaid enrollees in managed care (Schneider, 1997). When CHIP was enacted, it was envisioned that many of the same providers who were already serving Medicaid enrollees would also serve CHIP enrollees. Information on providers participating in CHIP and access to care for children under CHIP is not available yet.

To assure quality and access to care, state Medicaid agencies review data on consumer satisfaction, provision of translation services, provision of prenatal care and immunizations, and other performance measures used by health plans (see Figure 8) (Epstein 1997; Landon and Epstein, 1999; Landon et al., 1999).

However, states must specify and enforce requirements for information in contracts with health plans, actively oversee the provision of services, and require plans to provide clear information for consumers through report cards, Web sites, and other consumer-friendly media.

The most widely used performance measurement tool is the Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA) (www.ncqa.org). HEDIS measures of health care utilization, access and availability, and financial stability are used by hundreds of employers and by almost all states in their Medicaid managed care contracts.

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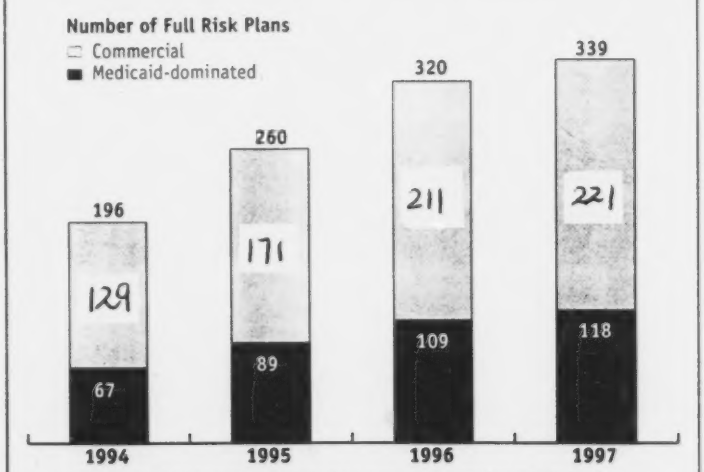
If children with Medicaid and CHIP coverage are enrolled in the same plans as privately insured children, the comparability of information across plans and across the nation could improve health plan accountability for access and quality of care for all children. For example, by comparing different health plans' performance on the HEDIS measures of immunization rates, well-child visits, treatment of ear infections, and availability of language interpretation services, it is possible to tell whether all children are receiving the same levels and quality of care.

However, unless states specify HEDIS data or other reporting requirements in health plan contracts in advance, and enforce those contract provisions, the performance data may not be collected by the plans or made available to states in a usable format when they need it.

FIGURE 9

Growth in Medicaid Managed Care Plans, 1994 to 1997



Note: Medicaid-dominated plans include those plans with greater than 75% Medicaid enrollment. Commercial plans include those with primarily private enrollment.

Source: Felt-Lisk S. *The Changing Medicaid Market: Trends in Commercial Plans' Participation.* Mathematica Policy Research, Inc., for the Kaiser Commission on Medicaid and the Uninsured. May 1999.

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Provider Participation

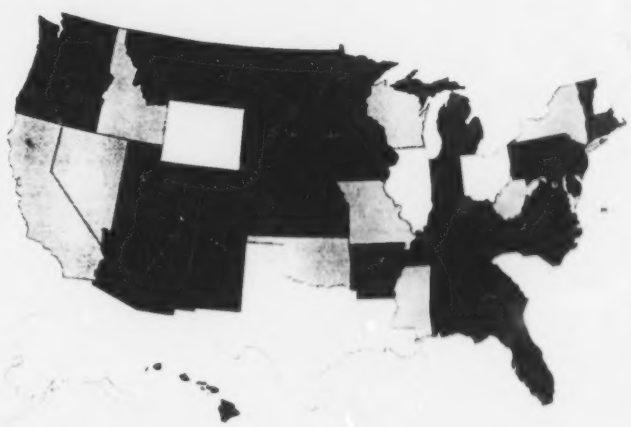
The success of Medicaid managed care relies heavily on the willingness of health plans to participate and to provide services to low-income populations (see Figure 9). Participation of commercial plans — those that serve the privately insured population with employer-based coverage — increases access to mainstream providers and preventive services. Even though some commercial plans have left the Medicaid market in some states, more than half of the enrollees in the 15 high-volume states are still served by commercial plans (Felt-Lisk, 1999).

Commercial plans and Medicaid plans are comparable in most ways, except that Medicaid plans are more likely to include programs targeted to the needs of low-income people, such as outreach, care management, transportation, child care, and other support services traditionally associated with safety-net providers (United Hospital Fund, 1999). More than half of the states now have at least half of their Medicaid participants in some form of managed care (see Figure 10).

"Nationally, an estimated total of 40 million insured children are in some form of managed care, including approximately 11 million children in Medicaid managed care."

FIGURE 10

Medicaid Managed Care Enrollment by State, 1998



* Includes the District of Columbia

Source: HCFA. *Medicaid Managed Care State Enrollment*, December 31, 1998. Available at www.hcfa.gov/medicaid/mcsten98.htm.

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"If children with Medicaid and CHIP coverage are enrolled in the same plans as privately insured children, the comparability of information across plans and across the nation could improve health plan accountability for access and quality of care for all children."

However, states' cost savings are achieved through discounted rates with health plans, primarily because pediatricians, dentists, and other providers receive lower payments compared with the rates paid by commercial plans in the private sector. The lack of payment equity between public- and private-sector providers has helped to perpetuate a two-tiered health care system, in which low-income groups have more barriers to care.

Private-Sector Coverage Trends

Two out of three American children have private insurance coverage through a parent's employer. The availability of employer-based coverage varies in different states and regions because of differences in the industrial and economic base, unemployment rates, distribution of large versus small employers, and regional perspectives on who should be responsible for health insurance coverage. For example, New England traditionally has a higher proportion of insured citizens than the South (Edmunds and Coye, 1998a).

On a national basis, nine out of 10 uninsured children have a working parent. Why don't these children have employer-based coverage? A disproportionate number of uninsured working Americans are employed by small businesses, where fewer firms offer coverage, premiums are higher, and employee contributions are higher (particularly for family coverage). Others are self-employed or not eligible for coverage because they are new employees, part-time, or temporary workers.

Small businesses account for more than 75% of job growth (SBA, 1998), but their employees are more likely to be uninsured.

- Of the 25 million workers who were uninsured in 1997, more than 60% were employed by businesses with fewer than 100 employees (Gabel et al., 1999a).
- Almost half of the uninsured workers are in firms with fewer than 25 employees, and most of them work for businesses that do not offer any health care benefits (Gabel et al., 1999a) (see Figure 11).
- Between 1996 and 1998, the percentage of small firms offering coverage dropped from 59% to 54% (Gabel et al., 1999a).
- More than two-thirds of the uninsured workers earn less than $20,000 per year (Gabel et al., 1999b).

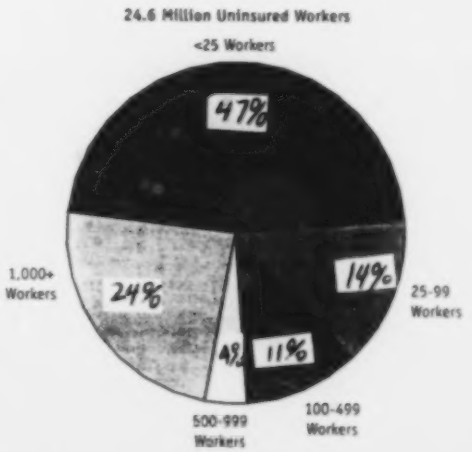
Compared with employees in large firms, employees in small firms have to pay more for family coverage (Gabel et al., 1999a) (see Table 13). The exception to this pattern is among small firms that provide higher wages (see Figure 12). Regardless of size, high-wage firms are

more likely to offer health benefits, and almost 90% of workers in high-wage firms choose to participate in their firm's health plan (Gabel et al., 1999b; see Figure 13). In small, low-wage firms, employees have to pay a larger proportion of the premium themselves, which is a higher dollar amount and a larger relative proportion of their income.

In sum, health care premiums are increasing more for small businesses than for large employers or other group purchasers. As a result, some small business owners are dropping coverage, and those who still offer coverage are passing along more of the costs to their employees. As costs increase, more workers are forced to drop coverage. Consequently, workers in small businesses — especially low-wage workers — are the most vulnerable in an employer-based health insurance system.

FIGURE 11

Almost Half of Uninsured Workers Are in Firms With Fewer Than 25 Employees



Source: Henry J. Kaiser Family Foundation and KPMG Peat Marwick. *Summary of Findings: Changes in Employee Health Coverage by Small Businesses*. Menlo Park, CA: February 1999. Figure 9, p. 7.

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"Nationally, about one-fourth of all businesses and about one out of three small businesses participate in some type of group purchasing arrangement."

TABLE 13

Monthly Family Coverage Costs More in Small Firms

Single Coverage: Small Firms

	Total Premium	Employee Contribution	Percent of Total
1996	$172	$55	32%
1998	$183	$39	21%

Single Coverage: Large Firms

	Total Premium	Employee Contribution	Percent of Total
1996	$170	$37	22%
1998	$173	$29	17%

Family Coverage: Small Firms

	Total Premium	Employee Contribution	Percent of Total
1996	$404	$178	44%
1998	$458	$194	42%

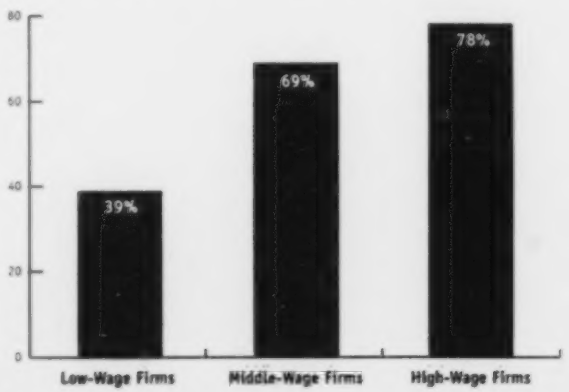
Family Coverage: Large Firms

	Total Premium	Employee Contribution	Percent of Total
1996	$441	$128	29%
1998	$462	$123	27%

Source: Adapted from Tables 9, 9A , 13, and 13A in J. Gabel et al. *Health Benefits of Small Employers in 1998*. Report prepared for the Henry J. Kaiser Family Foundation by KPMG Peat Marwick, February 1999.

FIGURE 12

More High-Wage Firms Offer Coverage



Note:
Low-wage firms—35% or more of workforce earn less than $20,000/year.
Medium-wage firms—between 10.11% - 34.99% of workforce earn less than $20,000/year.
High-wage firms—10% or less of workforce earn less than $20,000/year.

Source: The Henry J. Kaiser Family Foundation and KPMG Peat Marwick. *Summary of Findings: Changes in Employee Health Coverage by Small Businesses*. Figure 7, p. 6. Menlo Park, CA: Henry J. Kaiser Family Foundation. February 1999.

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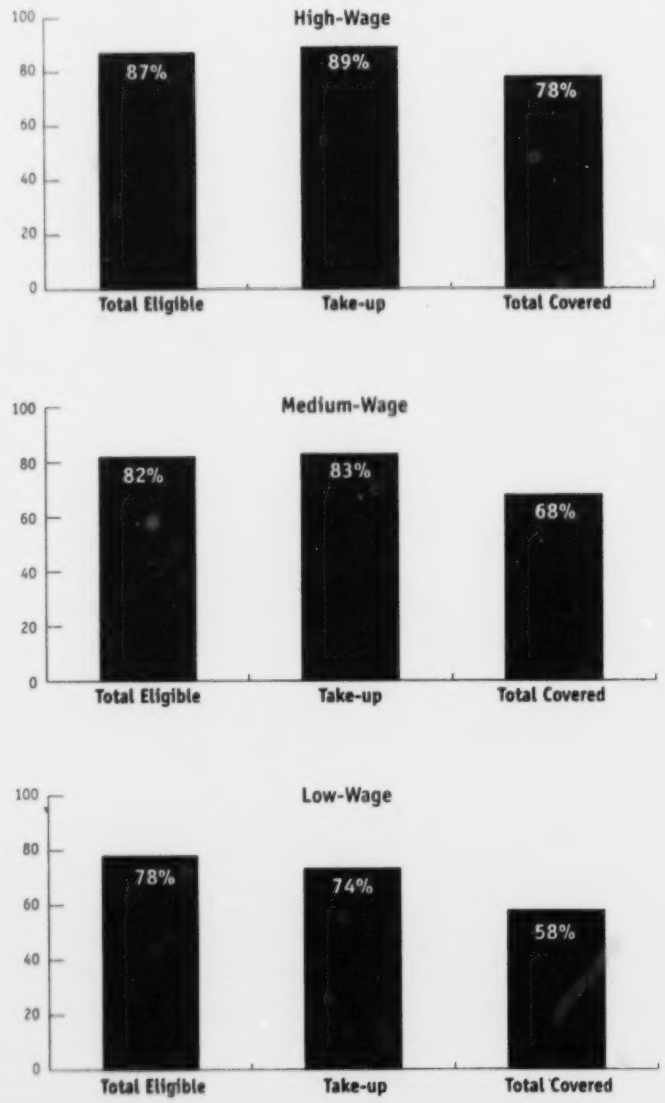
FIGURE 13

Lowest Take-Up Rates* Are in Low-Wage Firms



* Take-up rate is the percentage of employees that choose to participate in health insurance coverage.

Note:

Low-wage firms—35% or more of workforce earn less than $20,000/year.

Medium-wage firms—between 10.11% - 34.99% of workforce earn less than $20,000/year.

High-wage firms—10% or less of workforce earn less than $20,000/year.

Source: Adapted from the Henry J Kaiser family Foundation and KPMG Peat Marwick. *Summary of Findings: Changes in Employee Health Coverage by Small Businesses*, p. 6. Menlo Park, CA: Henry J. Kaiser Family Foundation. February 1999.

"Employees in small firms have to pay more for family coverage, compared with employees in large firms."

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In its first year of implementation, HIPAA faced significant industry resistance and operational difficulties. A GAO report found that some insurers were charging premiums for individual consumers that were 140% to 600% higher than standard rates.

Before she got a car, she and her daughter would leave home at 6:30 a.m., then catch light rail and a bus to get her daughter to day care and herself to work by 8 a.m. It was difficult for the mother, but it seemed to be killing her daughter, especially in winter, when the 6-year-old asthmatic was in the hospital every other month. So the mother got a car and, by doing so, lost her daughter's health insurance. Though she didn't know it, Colorado is one of six states to have an asset test for Medicaid. Acquire an asset worth more than $1,500 – like a car – and you've traded in health insurance for your children.

Carol Kreck, Staff Writer, *Denver Post*, February 16, 2000

Insurance Reform

In the early to mid-1990s, 45 out of 50 states enacted some kind of health insurance reform to make it easier for small businesses, the small group market, to provide affordable health coverage for their employees (Curtis et al., 1999; Hall, 1999; Oliver, 1999). During the same period, more than a dozen states passed legislation to help small employers establish purchasing cooperatives or coalitions.

Group purchasing helps employers get better rates with health plans because of increased administrative efficiency, such as standardized benefits packages, but it is still a new approach and results have varied in different parts of the country (Oliver, 1999; Wicks and Meyer, 1999). Nationally, about one-fourth of all businesses and about one out of three small businesses participate in some type of group purchasing arrangement (Long and Marquis, 1999).

Building on these state reforms, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to help individuals keep health insurance when they change jobs (i.e., to improve "portability" of coverage) and to guarantee access to health insurance for small businesses.

HIPAA also included new provisions to simplify and standardize medical information, thereby improving efficiency and reducing administrative costs (Atchinson and Fox, 1997; Oliver, 1999; Polzer, 1999). The new requirements will apply to all medical information that is transmitted electronically, and when adopted, the requirements are expected to have a major impact on medical information systems.

In its first year of implementation, HIPAA faced significant industry resistance and operational difficulties (Oliver, 1998; Polzer, 1999). The U.S. GAO (1998) found that some insurers were charging premiums for individual consumers that were 140% to 600% higher than standard rates, and significant delays in processing applications were reported. In summer 1998, the White House directed HCFA and the Office of Personnel Management, in collaboration with the National Association of Insurance Commissioners, to take strong action to ensure compliance with the law (White House, 1998).

Under HIPAA, health insurers may not refuse coverage to any small business. But HIPAA does not regulate insurance prices, and even though it has improved protections for millions of consumers with pre-existing medical conditions, it has had little effect, thus far, on the number of small businesses offering coverage.

"On a national basis, nine out of 10 uninsured children have a working parent."

Health insurance reforms have multiple purposes, but they all tend to converge on this central aim: to create a marketplace dynamic that will both promote health insurance coverage and restrain health insurance costs. This broad objective has a number of subsidiary components, which include increasing insurance availability, increasing its affordability, reducing risk selection and medical underwriting, leveling the playing field among insurers of different types with different operating strategies, and stabilizing the market. Others view the purposes in more political terms, as a means to improve the functioning of the private market so as to lessen the threat of a complete government takeover, or in some instances as a desire by one part of the industry to force others to bail them out or to compete on their terms. Thus, there is no single, cohesive view that characterizes all insurance reform efforts.

Mark Hall, *Health Insurance Market Reforms: Introduction and Background Analysis*, February, 1999

"Workers in small businesses — especially low-wage workers — are the most vulnerable in an employer-based health insurance system."

Implications for CHIP

As the CHIP program matures, states may be more likely to work with employers to improve coverage, particularly with small, low-wage employers such as child care centers or other stakeholders involved in CHIP outreach efforts (NGA, 1998). For example, the state of Rhode Island sponsors a small, state-only private coverage buy-in program for workers of child care centers with state contracts.

Through CHIP implementation, some states have shown interest in private coverage buy-in programs, in which CHIP funds subsidize families' incomes to help them participate in their employers' programs. The MassHealth Family Assistance Program, for example, subsidizes coverage for families who meet the income eligibility requirements and have access to employer-based coverage (Tollen, 1999).

States face significant challenges in developing and implementing subsidized programs. In order to obtain HCFA approval to use CHIP funds, states must set cost-sharing limits and ensure that the benefits are adequate. States also must design administrative systems to monitor families' contributions and expenses. Compliance with these requirements is essential to ensure that children receive the benefits and cost-sharing protections Congress intended. Very few states have tried this approach so far.

There is also renewed interest in forming new purchasing coalitions, despite their design and implementation challenges (Oliver, 1999; Wicks and Meyer, 1999), because so many parents of CHIP- and Medicaid-eligible children work for small businesses. In states such as California, Florida, and Connecticut, where purchasing coalitions are more successful, coalitions may be seen as a way to make insurance more affordable and to collect and share data on the quality of health plans' performance. However, issues related to consumer protection, structure of benefits, and state insurance regulations arise, especially when policy makers propose authorization of purchasing coalitions across state lines.

A little boy told his family how sick he felt, and his father knew he needed to see a doctor right away. Just a few weeks before, the father had applied for California's Healthy Families (CHIP) program. Fortunately, this little boy was able to receive treatment quickly. He was diagnosed with spinal meningitis and subsequently recovered.

Contributed by an outreach worker for
Healthy Families and Medi-Cal,
San Joaquin Valley of California, September 1999

My daughter complained of an earache, and I waited a few days before taking her to the doctor to see if she would feel better. I felt horrible waiting while my child was in pain, and I wondered if I would have waited if I had health insurance.

Mother of five children ages 5 to 17 in Los Angeles,
Participant in focus group conducted for
CDF by Fallon McElligott, 1998

Summary

CHIP's entry to the health care market has come at a time when employer-based enrollment and Medicaid enrollment trends are difficult to interpret. Private coverage rates have stayed about the same among higher-income families, but private coverage in the small group market continues to be disproportionately low. An economic slowdown could further erode the amount of private coverage offered by small businesses and increase the number of uninsured children in working families, thereby increasing the number of children eligible for CHIP.

Medicaid insures more children than any other single program, but state commitments to Medicaid populations are startlingly different. More than half of the states showed decreases in Medicaid enrollment between 1997 and 1998, and the majority of state information systems are not reliable enough to determine the reasons for the changes. HCFA has instructed states to restore coverage for those who should still have it and a new reporting system for Medicaid has gone into effect, but the previous inconsistencies in data may never be resolved.

Regional and state-to-state economic differences and varying levels of commitment to insurance expansions will influence the impact of CHIP. In sum, the net effect of CHIP will be determined by policies, preferences, and trends in both the public and private sectors.

A family learned that their four-year-old daughter needed glasses as soon as she began preschool. She could not see the blackboard or the picture books the teacher shared with the class. The girl's mother hoped they were eligible for Healthy Families, and she applied for the program right away. Once the little girl was enrolled, they had her eyes checked and she got glasses. After she tried them on, she ran outside with her mother and was able to see clearly for the first time in her life. Everything seemed to shine. She was so excited that she yelled, "The world is so bright! I see beautiful diamonds on the ground." Her mother cried tears of joy as her daughter told her she never wanted to take her glasses off.

Contributed by an outreach worker for
Healthy Families and Medi-Cal,
San Joaquin Valley of California, September 1999

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Recommendations

States have shown tremendous variability in designing their CHIP programs, and they have partnered with a wide spectrum of public- and private-sector entities to launch their programs. Volunteers, advocates, and celebrities have joined with federal and state agency officials; governors; legislators; health care providers; businesses; and national, state, and local organizations to spread the word about CHIP.

"CHIP has given states an opportunity to combine home-grown, community-based, door-to-door outreach programs with full-scale, creative social marketing approaches to help further the nation's goal of reducing the number of uninsured children."

CHIP has given states an opportunity to combine home-grown, community-based, door-to-door outreach programs with full-scale, creative social marketing approaches to help further the nation's goal of reducing the number of uninsured children. Over time, the most effective strategies will target public awareness campaigns to eligible families, provide application assistance, make the application process convenient, review applications quickly and efficiently, and teach families about their health plans so they will know how to access care when their children are sick or injured.

States must redouble their efforts to promote the image of CHIP and Medicaid as insurance programs. They must continue to remove both programs from the welfare culture and into the health care mainstream. More specifically, CDF recommends the following:

Coverage. **Expand coverage for CHIP and Medicaid as high as possible.**

By passing CHIP, the nation has adopted the goal of providing health coverage for children who are currently uninsured. States can make substantial progress toward that goal by covering uninsured children with family income of at least 200% of the Federal Poverty Level (FPL) and by aggressively enrolling eligible children in CHIP and Medicaid. Ten states already set eligibility above 200% of FPL for FY 1999, the time period covered in this report, and more states have made plans to increase eligibility levels. Other states should follow their lead.

"Bureaucratic administrative procedures and excessive documentation are the main barriers to enrolling more eligible children in CHIP and Medicaid."

When determining eligibility, states also must take into account the considerable work-related expenses low-income working families face, particularly child care and transportation.

RECOMMENDATIONS:

- **Set eligibility levels as high as possible beyond 200% of FPL.**
- **Deduct work-related expenses from family income when calculating eligibility for coverage through CHIP.**

Eligibility. **Raise income eligibility requirements to make them consistent for all ages of children through age 18 within a family.**

Many states still have different Medicaid eligibility requirements for children of different ages. Families are confused when one child is eligible for coverage and another is not, when children within the family are eligible for different programs, or when a child loses coverage after a birthday.

States should ensure that the same health plans and providers participate in both CHIP and Medicaid. This policy will allow children in the same family to visit the same clinicians even if their eligibility changes or if one of the children is covered by a different program. It also allows parents and children to develop long-term relationships with the same providers, which is especially important for children with chronic conditions and special health care needs.

RECOMMENDATIONS:

- **Make eligibility levels consistent for all ages of children within a family.**
- **Ensure that the same providers participate in both CHIP and Medicaid, so if eligibility changes, children can continue to see the same providers when they are sick or injured.**

***Simplification and Ease of Enrollment*. Streamline the CHIP and Medicaid application processes, make them user-friendly, and eliminate differences between them.**

Bureaucratic administrative procedures and excessive documentation are the main barriers to enrolling more eligible children in CHIP and Medicaid. A Kaiser Family Foundation survey found that six out of 10 parents with Medicaid-eligible children had tried to enroll in the program but did not succeed, usually because they found the process was too difficult and complicated (Kaiser Commission on Medicaid and the Uninsured, 2000).

Focusing on Medicaid's poor public image or stigma as a deterrent to enrolling misses the following key points: the majority of parents in the Kaiser study tried to enroll their children, said they liked and appreciated the program, and wanted coverage for their children (Kaiser Commission on Medicaid and the Uninsured, 2000). States should not make Medicaid enrollment more difficult than CHIP enrollment. Six states (Colorado, Montana, Nevada, North Dakota, Texas, and Utah) have dropped the asset test only for their CHIP program, leaving applicants for Medicaid with a more difficult enrollment process (Cox and Cohen Ross, 2000).

Most states have reduced their application length, but much more remains to be done to simplify the enrollment process and materials (Cox and Cohen Ross, 2000). For example, CDF-Ohio found that state and county Healthy Start/Medicaid applications and accompanying materials were written at the tenth- and twelfth-grade reading levels. By comparison, Internal Revenue Service 1040 Form and Schedules A and B are written at the sixth-grade level.

Many state and county computer systems are old, outdated, and difficult to use, and many eligibility workers must determine eligibility "by hand." If technical support and administrative procedures can not keep up with the needs of eligible children and families, many thousands of eligible people will continue to be turned away or turned down for the wrong reasons. By investing in computer upgrades and redesigning systems, states could verify eligibility on-the-spot by checking other data bases for public programs with similar income requirements.

States can do better. Improved efficiency, reduced administrative costs, and peace of mind for parents would be well worth the effort.

"Improved efficiency, reduced administrative costs, and peace of mind for parents would be well worth the effort."

"The intent of the CHIP legislation was to provide child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."

RECOMMENDATIONS:

- **Simplify the eligibility rules and provide simple explanations of the rules.**
- **Make CHIP and Medicaid enrollment processes the same.**
- **Eliminate waiting periods.**
- **Reduce excessive, unnecessary paperwork.**
- **Eliminate unnecessary documentation requirements.**
- **Eliminate asset tests and face-to-face interviews in welfare offices.**
- **Allow families to self-declare information.**
- **Implement presumptive eligibility, which allows a child to become enrolled immediately and receive services while an application is still pending administrative review. (Only five states currently offer presumptive eligibility under CHIP and only seven under Medicaid.)**
- **Upgrade computer systems.**

Improved and Expanded Outreach. **Intensify efforts to help children get enrolled in CHIP and Medicaid.**

Behind every child enrolled in CHIP and Medicaid, there are several individuals in the public and private sectors working to make the enrollment successful. Countless public officials, advocates, volunteers, community leaders, providers, teachers, students, and celebrities across the country have been contributing their time and resources to help the program succeed. These efforts need to continue until every eligible child has been enrolled.

RECOMMENDATIONS:

- **Continue to raise public awareness about CHIP and changes in Medicaid.**
- **Develop more targeted outreach and enrollment campaigns in health care clinics, schools, and other community settings.**
- **Expand the number of "partners" involved in outreach and enrollment campaigns, including businesses, civic organizations, and the faith community.**
- **Provide culturally appropriate application assistance, including translation services and applications in several languages.**

Continuous Enrollment. **Help children stay enrolled in CHIP and Medicaid through 12-month continuous eligibility.**

In low-income families, income can be unpredictable and can fluctuate from month to month. Unless a state has continuous enrollment policies for families at the margins of eligibility, children may be required to drop and re-apply for coverage according to the family's current circumstances, even when income differences are relatively small amounts.

While implementing welfare reform, few states kept track of the children who still should be covered by Medicaid and lost coverage because of state or county administrative or computer errors, diversion programs, or other barriers. Turnover in enrollment, or churning, is a major problem because it produces gaps in coverage, and because uninsured children usually can not get care when they need it. Turnover also creates significant administrative burdens for states.

Many states require families to re-apply for Medicaid and CHIP every six months. Fewer than half of the states offer continuous, 12-month eligibility for CHIP, and only one-third of the states offer continuous eligibility for Medicaid enrollees (Cox and Cohen Ross, 2000). Continuous eligibility not only reduces administrative burdens, but it improves the likelihood of including CHIP and Medicaid enrollees in assessments of access and quality. Health plans typically require members to be enrolled for at least 12 months in order to be included in quality assurance reports.

Among uninsured children, about one out of five citizen children have at least one non-citizen parent.

RECOMMENDATIONS:

- **Implement 12-month, continuous eligibility for CHIP and Medicaid in every state.**
- **Make it easy to renew eligibility.**
- **Monitor the reasons for disenrollment, including state and county administrative and computer errors, families moving to new addresses, and parents of newly insured children who do not understand the importance of continuous coverage even when their children are healthy.**
- **Monitor the impact of cost-sharing (premiums and copayments) on families. Help to document families' financial burdens and ensure the affordability of enrollment and access to services.**

"Although *pediatricians* provide more than twice as much care to Medicaid enrollees as other physicians, their average reimbursement is less than half of private market rates and does not even cover their overhead expenses."

Program Coordination and Integration. **Improve coordination between CHIP and Medicaid, and coordinate both with other programs for low-income families.**

The intent of the CHIP legislation was to provide "child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children" (P.L. 105-33). Many Medicaid programs have simplified their application and enrollment procedures to make them comparable to CHIP, and HCFA has encouraged but not required additional simplifications.

Almost three-quarters of low-income uninsured children live in families that participate in the National School Lunch, Food Stamp, Unemployment Compensation, or Women, Infants, and Children's Nutrition (WIC) programs (Kenney, Haley, and Ullman, 1999). Approaches such as Express Lane Eligibility have emerged to accelerate enrollment efforts for uninsured children who are already enrolled in public programs with income requirements similar to Medicaid and CHIP (Horner, Lazarus, and Morrow, 1999). States should develop similar approaches that allow expedited reviews for children enrolled in other public programs.

RECOMMENDATIONS:

- **Resolve differences in documentation and other administrative requirements among public agencies to allow expedited eligibility reviews for CHIP and Medicaid.**
- **Explore new ways to reach eligible children such as enrollment campaigns aimed at children participating in Title I of the Elementary and Secondary Education Act programs or school lunch programs.** (Note: Federal legislation enacted in June 2000 will allow school districts to enter into agreements with child health agencies to help ensure that all children in federal free and reduced school lunch programs can be contacted regarding CHIP and Medicaid enrollment.)
- **Ensure that health plans serving CHIP and Medicaid participants provide comparable information on health care access and quality for both programs.**

Cultural Competence. **Recognize diversity and improve cultural sensitivity in all systems that serve children and families.**

Racial and ethnic minorities are the fastest growing segment of the population, and the Department of Health and Human Services has set the goal of ending racial and ethnic disparities in health status in key areas by 2010 (http://raceandhealth.hhs.gov). Without significant improvements in health coverage and access to care, the nation will be unlikely to meet this goal.

Among the goals involved in the race and health initiative is improving the health care system's capacity to provide culturally competent care to an increasingly diverse population. Racial and ethnic minorities make up less than 10% of the health care workforce, so mainstream providers need to be more culturally aware by incorporating translation services, using multilingual print materials, and recognizing cultural traditions when providing health services for ethnically and culturally diverse consumers. In the long term, more people of color need to be encouraged to enter the health care workforce as physicians, dentists, nurses, and other health professionals.

Much more needs to be done to make administrative and health care systems culturally competent and family-friendly, particularly in states with large numbers of immigrant families, so that these parents will take the step of enrolling their eligible children and accessing care.

RECOMMENDATIONS:

- **Engage community-based organizations in outreach and care coordination in racially and ethnically diverse communities.**
- **Increase the diversity of the workforce by using incentives to encourage minority students to enter health professions.**
- **Train and certify more community health workers to work with communities of color, including the recruitment and training of youth to work in their own communities.**

To sustain effective CHIP and Medicaid programs and to guide future insurance expansions, it will be important to compare approaches and to distinguish what works best for different groups, different states, and different regions.

Immigrant Children. **Intensify efforts to reach and enroll children in immigrant families.**

Among uninsured children, about one out of five citizen children have at least one non-citizen parent (CDF calculations, May 2000, based on March 1999 Current Population Survey, Bureau of the Census). Immigrant parents face special problems in accessing coverage and care for their children: language barriers, cultural differences in health practices, and reluctance to contact public agencies because of fears related to immigration status.

Under the welfare law of 1996, several restrictions were placed on legal immigrants' access to programs such as Medicaid and CHIP. Under that law, legal immigrant children who entered the country after August 22, 1996, must wait five years to be covered through CHIP or Medicaid, with the exception of emergency services. Thus, federal law prevents these children from receiving health insurance even though their parents are typically workers who pay taxes. The Clinton administration estimated that more than 50,000 children were

affected by these restrictions, and more than a dozen states are using their own funds to provide health benefits for immigrant children who are not eligible for CHIP and Medicaid through other programs (Zimmerman and Tumlin, 1999).

Recent immigration and welfare laws generated public confusion and concern about whether non-citizens who are legally eligible to receive certain public benefits would face negative immigration consequences if they received those benefits. Until the federal government clarified its standards, immigrant parents were afraid to enroll immigrant or citizen children in CHIP. A remaining policy that creates problems is "sponsor deeming," which may make families afraid to participate in programs because their sponsors may be held financially responsible for certain expenses.

In May 1999, the Immigration and Naturalization Service (INS, 1999) clarified that non-citizens may receive CHIP, Medicaid, immunizations, and certain other benefits without becoming a "public charge" and having a negative effect on their residency and immigration status. Previously, however, some immigrants had been illegally detained at the border or prevented from getting a green card because of their legal participation in Medicaid and other programs (National Health Law Program, 1999).

Confusion about who is eligible has been a serious barrier to successful outreach efforts. Immigrants and their family members are still afraid to enroll in health insurance, even though their participation has been clarified by federal authorities as legal. Immigrants and their family members need to be reassured that it is safe and beneficial to participate in health insurance programs.

RECOMMENDATIONS:

- **Ensure that all children have health coverage regardless of immigration status.**
- **Adopt federal legislation giving states the option to cover legal immigrant children and pregnant women through CHIP and Medicaid.**
- **Use state funds to insure immigrant children who are otherwise ineligible for coverage through CHIP and Medicaid.**
- **Ensure that enrollment procedures do not require unnecessary documentation, such as parents' Social Security numbers.**
- **Get the word out about public charge in immigrant communities, and provide translation and application assistance services.**
- **Eliminate policies such as sponsor deeming that interfere with enrollment and coverage of immigrant children.**

Provider Participation. **Recruit more providers for CHIP and Medicaid to improve access to care for low-income people, and make payment rates comparable to the commercial market.**

Provider shortages have long been a problem with Medicaid because of low payment rates, burdensome administrative requirements, and inefficient payment systems. If CHIP reimbursement rates are higher than Medicaid rates, medical and dental providers are not likely to increase Medicaid participation enough to meet the needs for care.

Provider shortages are common in medically underserved areas, such as low-income urban neighborhoods or rural and frontier areas, where most Medicaid enrollees live. When there is a shortage of physicians and dentists participating in Medicaid, people who need care will go to hospital emergency rooms, which have long waits to see a provider, limited follow-up, little or no health education about preventive strategies, and higher costs.

Although pediatricians provide more than twice as much care to Medicaid enrollees as other physicians (AMA, 1998), their average reimbursement is less than half of private market rates (Colby, 1994) and does not even cover their overhead expenses (AMA, 1998). For dental care, Medicaid funding covers only about 10% of the actual costs (American Dental Association, 1999; Edelstein, 1998). To ensure that children enrolled in CHIP receive care when they need it, the number of participating providers must be adequate to meet the need, and reimbursement rates must cover actual costs.

RECOMMENDATIONS:

- **Make the payment rates for CHIP and Medicaid comparable to commercial rates.**
- **Simplify the administrative procedures and streamline reporting requirements for providers so a core set of standardized information on all children is available, regardless of type of coverage.**
- **Recruit the same providers to participate in CHIP and Medicaid so children can keep the same provider if they need to change coverage because of changes in program eligibility.**
- **Expand CHIP benefits to ensure a comprehensive, child-appropriate package so clinicians can provide clinically appropriate care in all cases.**
- **Encourage providers to use 24-hour advice lines to improve access for families.**
- **Ensure that adequate numbers of pediatricians and pediatric subspecialists participate in health plans so children with special health care needs can have timely access to appropriate care.**

***Accountability*. Hold CHIP and Medicaid agencies accountable for providing all covered services, including medical, dental, vision, hearing, behavioral (mental) health, case management, and support services, and for providing information on utilization of those services.**

CHIP allows for flexibility and innovation in state programs, but the program's effects also need to be evaluated on a national basis to ensure that the funds actually improve children's insurance coverage and access to health care. Previous experience with Medicaid shows that children do not always have access to the full array of services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which specifically includes vision, hearing, dental, and mental health screenings, diagnostic evaluations, and any treatments that are medically necessary. In addition, children on Medicaid are three times more likely to be exposed to lead, but only one out of three is screened for lead poisoning (U.S. GAO, 1999b).

To sustain effective programs and to guide future insurance expansions, it will be important to compare approaches and to distinguish what works best for different groups, different states, and different regions.

RECOMMENDATIONS:

- **Ensure that state contracts with health plans require reporting on access, utilization, and outcomes of medical, dental, vision, hearing, behavioral health, and other services.**
- **Require participating health plans to prepare child-specific report cards on immunization rates, well-child visits, and screenings for dental, vision, hearing, behavioral health problems, and lead poisoning.**

Better Information. **Improve the use of information technology to streamline enrollment and provide the public with information on program performance at the national, state, and local levels.**

Every state's CHIP program is designed and implemented differently. With so much variation in design and implementation, how will we know whether CHIP and Medicaid are effective in reducing the number of uninsured children? How will we know whether a given CHIP program is effectively and efficiently providing affordable care?

Outdated computer systems can not keep up with the technical demands for the timely processing and analysis of information to help answer these questions. Medicaid software upgrades are a low priority in many states (Ellwood, 1999).

To make timely policy and advocacy decisions, accurate and current or real-time information is needed to make the best assessments of where to go next. Although consistent information on the CHIP program has been slow to emerge, federal, state, and local officials, advocates, and providers involved in implementing CHIP are accountable to the general public and to each other.

RECOMMENDATIONS:

- **Make national and state enrollment information available to the public on a monthly basis by posting information on Web sites.**
- **Make enrollment figures available by race, ethnicity, gender, and age to allow more targeted outreach efforts and assessments of what is working in particular communities.**
- **Ensure that health plans meet contractual requirements to provide all covered benefits.**

Family Coverage. **Secure funding to provide insurance coverage for parents of children in CHIP and Medicaid.**

Nine out of 10 uninsured children have at least one working parent, giving children potential access to employer-based health insurance. Under the CHIP statute, states can subsidize parents' coverage if states can show cost savings compared with individual coverage for children. In the FY 2001 budget, the Clinton administration has proposed new funding to encourage expanding coverage for parents.

Family coverage expansions make sense for many reasons. It is much easier for families if they are covered under the same insurer and receive all of their health care services from the same health plan with the same benefits and provider groups for all of their children. Expanding coverage for parents helps to improve children's coverage and access to care (Thorpe and Florence, 1998), and children whose parents are insured are more likely to use health care services (Hanson, 1998).

Most private policies are for family coverage, whereas Medicaid's EPSDT and CHIP plans provide benefits packages specifically oriented toward children. Family coverage is a more cost-efficient way to increase the number of insured adults and children (Tollen, 1999), but the benefits must be affordable and include child-oriented services.

Conclusion

Over time, the net effect of CHIP will be influenced by many competing trends, policies, and preferences in the public and private sectors. CHIP enters the health care market at a time when employer-based coverage and Medicaid enrollment trends are in flux. This environment encourages us to find new ways to enroll eligible children and to make sure they are able to stay in programs long enough to gain access to health care providers.

Our nation has the resources to make coverage and access to care a reality for every child. Increasing coverage and access to affordable, high-quality health care must remain at the top of the national agenda until all children have the coverage they deserve.

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WEB SITES AND ADDITIONAL RESOURCES

POLICY AND RESEARCH ORGANIZATIONS

The Alpha Center
www.ac.org
A non-partisan research organization that provides information, analysis, and strategic planning advice to public and private sector clients on state and national health care policy issues; funded as a program office by the Robert Wood Johnson Foundation.

Center on Budget and Policy Priorities
www.cbpp.org
A non-partisan policy institute that conducts research and analysis on a range of government policies and programs, with an emphasis on those affecting low- and moderate-income people.

Center for Health Care Strategies
www.chcs.org
A non-profit, non-partisan policy and resource center whose activities include providing technical assistance and information to groups that work to provide health care to children and families in low-income communities; funded as a program office by the Robert Wood Johnson Foundation.

Center for Health Services Research and Policy
www.gwu.edu/~chsrp/
Affiliated with GWU Medical Center, CHSRP conducts research and policy analysis on federal and state health issues; also produces a quarterly child health newsletter. CHSRP is funded by federal contracts and foundation grants.

Center for Studying Health System Change (HSC)
www.hschange.com
HSC's major initiative includes tracking the effects of health care system changes on people at the community level; affiliated with Mathematica Policy Research and funded by the Robert Wood Johnson Foundation.

Children's Dental Health Project
www.childent.org
A policy research organization dedicated to improving children's oral health and increasing their access to dental care. Provides technical assistance and information services to policy makers, health care providers, and parents. CDHP is affiliated with the American Academy of Pediatric Dentistry and the American Academy of Pediatrics.

Children's Partnership
www.childrenspartnership.org
A non-profit, non-partisan research organization that conducts policy research and analysis on emerging issues affecting children, including implementation of CHIP.

Child Trends, Inc.
www.childtrends.org
A non-profit, non-partisan research organization that studies children, youth, and families through research, data collection, and data analysis.

Employee Benefits Research Institute (EBRI)
www.ebri.org
A non-profit, non-partisan research organization that disseminates information on economic trends and employee health insurance coverage.

Maternal and Child Health Policy Research Center
www.mchpolicy.org
An independent health policy group whose projects include researching CHIP design and implementation and children's health insurance coverage.

Mathematica Policy Research
www.mathematica-mpr.com
A policy research and analysis firm that evaluates federal and state government programs including children's health insurance and welfare programs; affiliated with the Center for Studying Health System Change.

National Academy for State Health Policy
www.nashp.org
A non-profit policy analysis organization that conducts studies, convenes meetings, and provides technical assistance to states. Current programs include a CHIP Implementation Center.

National Center for Education on Maternal and Child Health (NCEMCH)
www.ncemch.org
Affiliated with Georgetown University, NCEMCH conducts studies and disseminates information on maternal and child health issues.

The Urban Institute
www.urban.org
A non-profit, non-partisan social policy research organization funded by government agencies, corporations, and other organizations. Special projects include studies of devolution in the areas of CHIP, income security, job training, and social services.

The Rand Corporation
www.rand.org
A non-profit, non-partisan policy research organization funded by government and private sector contracts. Operates several joint centers with UCLA in health policy research.

Appendix

FOUNDATIONS

Annie E. Casey Foundation
www.aecf.org
A charitable organization that provides data and analysis to policy makers, professionals, and the public relating to disadvantaged children and their families. Grants are given to initiatives that have significant potential to demonstrate innovative policy, service delivery, and community support for children and families.

The Commonwealth Fund
www.cmwf.org
A philanthropic organization that provides grants for independent research on health and social issues; funded projects include a Pediatric Developmental Services Program and Healthy Steps for Young Children Program. Grants are given to innovative projects that intend to improve the national health care system, particularly in its service to underserved populations.

Grantmakers in Health (GIH)
www.gih.org
A non-profit education and membership organization that seeks to help philanthropic organizations make informed decisions about the provision of grants to health-related projects and organizations.

The Kaiser Family Foundation
www.kff.org
A philanthropic organization that disseminates health policy analysis with an emphasis on issues affecting low-income children and families. Publishes regular reports on Medicaid, CHIP, and the uninsured population.

The John D. and Catherine T. MacArthur Foundation
www.macfdn.org
A philanthropic organization whose grants help the development of healthy individuals and communities. The foundation pursues this mission through supporting research, policy development, dissemination, education, training, and practice.

The David and Lucile Packard Foundation
www.cs.virginia.edu/packard
A philanthropic organization whose grant created the Lucile Salter Packard Children's Hospital and the tri-annual report entitled "The Future of Children." Grants are given to projects that help ensure the good health and well-being of children.

The Robert Wood Johnson Foundation
www.rwjf.org
A philanthropic organization that seeks to improve the quality of and increase access to health care; projects funded include Covering Kids—an initiative to help increase the number of children enrolled in state CHIP programs. Grants are given to projects that improve access to health care and the service of health care systems and that promote healthy behavior.

The W.K. Kellogg Foundation
www.wkkf.org
A philanthropic organization whose interests include improving health care systems worldwide; initiatives include Community Voices, a program dedicated to improving access to health care for underserved populations. Grants are given to projects that improve the welfare and health of citizens around the world.

The William T. Grant Foundation
www.fdncenter.org/grantmaker/wtgrant
A philanthropic organization that provides grants primarily to post-doctoral research projects focused on child and adolescent development. Grants are given to research projects that focus on the positive development of children, adolescents, and youth.

NATIONAL ORGANIZATIONS

American Academy of Pediatrics (AAP)
www.aap.org
A national membership organization (55,000 member pediatricians) with state chapters, national committees, and national, professional, and legislative staff. Provides continuing education, develops position statements, and disseminates information.

American Association of Health Plans (AAHP)
www.aahp.org
The national membership organization for managed care organizations. Has launched a five-year initiative with the Maternal and Child Health Bureau (MCH) of the Health Resources and Services Administration (HRSA) to address the health needs of mothers and children served by managed care plans.

American Public Health Association (APHA)
www.apha.org
A membership organization of 55,000 public health professionals. Addresses the full spectrum of health issues including funding for federal and state programs for health care coverage.

American Public Human Services Association (APHSA)
www.aphsa.org
A non-profit, bipartisan membership organization whose members include all state and many territorial human service agencies. APHSA educates members of Congress, the media, and the broader public on the status of welfare, child welfare, health care reform, and other issues involving families and the elderly.

Association of Maternal and Child Health Programs (AMCHP)
www.amchp.org
A non-profit organization that represents state public health leaders and others working to improve the health of children, youth, and families, including those with special health care needs. Provides technical assistance to programs funded by the Title V Maternal and Child Health Block Grant.

Association of State and Territorial Health Officials (ASTHO)
www.astho.org
A non-profit public health resource organization whose members are state and territorial health officials. Issue areas include access to care, environmental health, and public health infrastructure.

Children's Defense Fund
www.childrensdefense.org
A private, non-profit organization supported by foundations, corporation grants, and individual donations. Provides technical assistance, public education, and policy research and advocacy in a variety of areas affecting children, including CHIP and Medicaid.

Child Welfare League of America
www.cwla.org
A non-profit, non-partisan organization that seeks to improve the quality of life for at-risk children through direct services and policy research.

Families USA
www.familiesusa.org
A non-profit, non-partisan organization working at the national, state, and local levels to ensure high-quality, affordable health care for all.

Family Voices
www.familyvoices.org
A non-partisan advocacy organization that disseminates information and education about the health care of children with special health needs.

National Assembly on School-Based Health Care
www.nasbhc.org
A non-profit advocacy organization that represents school-based health care providers; works to make school-based health care more accessible and effective.

National Association of Child Advocates (NACA)
www.childadvocacy.org
National membership organization consisting of child advocacy organizations working to strengthen interaction between state and local child advocates. Focuses on the efficacy of CHIP implementation.

National Association of Children's Hospitals
www.childrenshospitals.net/nach
A non-profit membership association that helps children's hospitals address public policy issues pertaining to children's health, health care financing, graduate medical education, and more.

National Association of County and City Health Officials
www.naccho.org
A non-profit membership organization for local health officials. Provides research and technical assistance to local health officials and strengthens interaction between federal, state, and local public health groups.

National Association of School Nurses
www.nasn.org
A non-profit specialty nursing organization that seeks to strengthen health services to children in schools.

National Coalition on Health Care
www.americashealth.org
A non-profit, non-partisan alliance that seeks to expand health care coverage and improve its quality through policy research.

National Governors' Association (NGA)
www.nga.org
A national, bipartisan organization whose members are the nation's governors. Projects include improving maternal and child health and examining implementation of state CHIP programs.

National Maternal and Child Health Clearinghouse
www.nmchc.org
A non-profit, federally funded program that disseminates educational material on issues pertaining to the health of mothers and children.

National School Board Association
www.nsba.org
A national advocacy and outreach organization that provides training, technical assistance, and information to state school boards in order to promote the healthy development of children.

HEALTH CARE PROVIDERS AND OTHERS

Children's Health Fund
www.childrenshealthfund.org
CHF provides health care to medically underserved children through the development and support of innovative primary care medical programs, such as mobile vans.

Covering Kids
www.coveringkids.org
A national, three-year, outreach initiative sponsored by the Robert Wood Johnson Foundation that focuses on CHIP and Medicaid enrollees.

HOPE for Kids
www.hopeww.org
A national, volunteer-based organization that disseminates information about various children's health issues including immunization and children's health insurance.

The Institute for Child Health Policy
www.ichp.edu
A statewide institution of Florida's State University System integrating the resources of the state's universities to assist in the formulation and evaluation of health policies, programs, and systems.

Kids Count
www.aecf.org/kidscount
An Annie E. Casey Foundation initiative, Kids Count is a national and state-by-state effort to monitor the status of children in the United States.

School Health at the American Academy of Pediatrics
www.schoolhealth.org
A subsidiary of AAP, the School Health program disseminates information to pediatricians and other public health practitioners to help provide improved and high-quality health care to children.

Society for Adolescent Medicine
www.adolescenthealth.org
A multidisciplinary organization of health professionals committed to improving the physical and psychological health and well-being of adolescents through research, awareness, and training.

Southern Institute on Children and Families
www.kidsouth.org
A non-profit, public policy organization that focuses on improving the lives of disadvantaged children in the South, including facilitating access to health care.

United Way
www.unitedway.org
Governed by a volunteer board, the United Way provides health services, job training, and more to underserved populations.

GOVERNMENT AGENCIES

Agency for Healthcare Research and Quality (AHRQ)
www.ahrq.gov
A division of the Department of Health and Human Services, AHRQ conducts research designed to improve the quality of health care, reduce its cost, and broaden access to essential services.

Centers for Disease Control and Prevention, Division of Adolescent and School Health
www.cdc.gov/nccdph/dash/ataglanc.htm
A division of CDC, the School Health Initiative seeks to further involve school administrators and health practitioners in improving the lives of children.

General Accounting Office (GAO)
www.gao.gov
The investigative agency for Congress, the GAO responds to Congressional requests to monitor and evaluate federally sponsored programs.

Health Care Financing Administration (HCFA)
www.hcfa.gov
An agency of the Department of Health and Human Services, HCFA administers Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP), in collaboration with HRSA and other agencies.

Health Resources and Services Administration (HRSA)
www.hrsa.gov
An agency of the Department of Health and Human Services, HRSA directs national health programs that improve the health of the nation by removing barriers to quality health care for underserved populations. HRSA's Maternal and Child Health Bureau helps administer CHIP.

Insure Kids Now
www.insurekidsnow.gov
Insure Kids Now provides information to families with children who qualify for CHIP; also supplies information on state programs, and various tools for outreach in communities and schools.

U.S. Bureau of the Census
www.census.gov
The Bureau of the Census compiles data in various fields including the numbers of uninsured children from state to state as well as the status of children's health care. The Bureau of the Census disseminates this information to assist policy makers in administering a variety of national programs.

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